Australian Government
Department of Health

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Primary Health Network

Needs Assessment Reporting Template: AOD (updated November 2016)

This template must be used to submit the Primary Health Network's (PHN's) Needs Assessment report to the Department of Health (the Department) by **15 November 2016** as required under Item E.5 of the PHN Core Funding Schedule under the Standard Funding Agreement with the Commonwealth. This template should include the needs assessment of primary health care after hours services.

To streamline reporting requirements, the Initial Drug and Alcohol Treatment Needs Assessment Report and Initial Mental Health and Suicide Prevention Needs Assessment Report can be included in this template as long as they are discretely identified with clear headings.

Name of Primary Health Network

Nepean Blue Mountains

When submitting this Needs Assessment Report to the Department of Health, the PHN must ensure that all internal clearances have been obtained and the Report has been endorsed by the CEO.

Section 1 – Narrative: AOD

May 2016

Based on this Needs Assessment, high priority needs for improved coordination, integration and direct service delivery have been identified as:

- Risky substance behaviour including risky drinking, poly-drug use (especially methamphetamine use) among youth
- Local early intervention programs targeted at youth
- Education to support workforce capacity building and improved response to increasing demand for AOD services and increasing complexity of AOD problems including professional and non-specialist health and community workers
- Education to build capacity within the broader community and better equip community members to respond to increasing substance use, particularly methamphetamine use
- Local non-residential rehabilitation programs for men and women
- Local residential rehabilitation programs for men and women
- Extended treatment hours for existing AOD (including counselling)
- Improved aftercare within existing treatment models
- Improved support of people with dual diagnosis (mental health and AOD problems).
- Increased capacity and development of the NGO sector to provide enhanced and additional local AOD services.

High priority needs for improved coordination, integration and direct service delivery for Aboriginal people have been identified as:

- Enhanced service provision to support complex needs such as dual diagnosis (mental health and AOD problems)
- Improved assessment of people with complex problems that include AOD
- Case management for people with complex AOD problems
- Culturally secure service provision for youth with AOD problems
- Culturally secure service provision of non-residential rehabilitation programs.

Stakeholder consultations conducted as part of preparation of this Needs Assessment are:

- NADA CEO, deputy CEO and Clinical Director
- Aboriginal community coalitions Blue Mountains, Penrith, Hawkesbury and Lithgow as part of ongoing communication and as part of 2015 Sharing Learning Circles conducted in each of the four LGAs during 2015
- Blue Mountains Healthy for Life program
- NBM Close the Gap Care Coordination and Supplementary Services (CCSS)
- NBMLHN AOD Strategic Planning Forum, February 2016 involving NGOs, Aboriginal health representatives, NBMLHD AOD personnel and consumer representatives
- General Manager Drug and Alcohol Services, NBMLHD
- NBMPHN ATAPS Manager
- NBMPHN PIR Regional Manager

- Blue Mountains Drug and Alcohol Recovery Services Inc. as part of Project Skylight (2010). This project consulted with local general practice, specialist AOD and community based service providers, and conducted focus groups with youth groups
- General Manager, Lyndon Community
- CEO, Deputy CEO and Program Manager, 180TC Kurmond
- NBMPHN Mental Health Forum, 23 February 2016 and structured telephone interviews with stakeholders selected from NBM general practitioners and allied health professionals for mental health and AOD feedback concerning health and service needs (referred to throughout the Needs Assessment as NBMPHN Preliminary Stakeholder Consultations for Drug and Alcohol, 2016).

Stakeholder consultations to be conducted prior to 1 July 2016 by telephone and face to face are:

- Aboriginal Health and Medical Research Council NSW
- Marrin Weejali Aboriginal Corporation, Emerton
- Community Drug Action Team (CDAT) Blue Mountains, including representatives from Police youth liaison, Department of Education, Blue Mountains Council Youth Services Development and a range of service providers
- MYST (Mountains Youth Services Team)
- Dianella Cottage, Katoomba (as part of Lyndon Community)
- Family Drug Support Australia, Leura
- Barnardo's Penrith
- WHOs Penrith
- And others to be identified through interviews.

NBMLHD will be a key and active partner in the development and commissioning of all AOD activities.

Two advisory groups will be established to provide key stakeholder input across all activities and oversight of the commissioning processes. One of these will be Aboriginal specific. The advisory groups will be established during prior to 30 September 2016.

An AOD Symposium will be held before 31 December 2016 to bring together the knowledge and expertise of a range of stakeholders as part of a collaborative process. In view of the relatively small number and capacity of most local NGO providers of AOD services, and the likely need to facilitate partnerships among different providers, the aim of the symposium will be to initiate a soft marking sounding approach to commissioning of a range of activities. Open dialogue with service providers will be directed towards supporting the development of likely commissioning options, as part of regional planning.

Discussion papers will be distributed to Symposium participants to obtain direct input into commission strategies. Follow up surveys may also be conducted after the event.

Community based feedback will be initially sought through partner organisations such as CDAT, Family Drug Support Australia, and others to be identified. Strategies for the involvement of community representatives in regional planning and ongoing feedback will be developed in consultation with AOD advisory groups (to be established), the NBMPHN Community Advisory Committee, and key stakeholder organisations such as those already mentioned.

November 2016 Update

This updated Needs Assessment for Alcohol and Other Drugs (AOD) has expanded on:

- Drug and alcohol treatment health and service needs, and priorities, specific to the Indigenous population
- Additional information from stakeholder consultations
- Opportunities, priorities and options.

- **Overview**

This six-month update report of needs assessment has focused primarily on the health and service needs for Aboriginal people, supported with new information obtained from local reports including community forums held in each of the LGA between September-October 2016. Other updated information concerns the likely prevalence of substance use in the NBM region. Ongoing investigations for assessment of regional needs will include an examination of the AOD treatment and support needs of people who have been released from detention in the region. These are: Dillwynia medium and minimum security for women collocated with John Morony compulsory drug treatment centre at Berkshire Park; Lithgow Correctional Centre, maximum security for men; Emu Plains minimum security for women; Cobham Juvenile Justice Centre St Mary's for young men. Anecdotal information indicates that local support services are required for new releases from detention who remain in the region and who may be particularly vulnerable to relapsing into risky substance use.

- **Identified priorities**

There are no substantive changes to high priority needs that have been previously identified. The following discussion of updates involves new information to support existing high priorities.

- **Identification of priorities for services provided to Aboriginal people**

Community consultation forums conducted in each of the four LGAs indicate that there is a wide range of service gaps experienced by Aboriginal people across the spectrum of AOD service provision. A range of socioeconomic and cultural barriers to access were commonly described by NBM Aboriginal community representatives during these forums. Together these barriers can be described as preventing Aboriginal people from contacting AOD service providers for voluntary access to preventative education, voluntary assessment and early intervention, as well as other treatment related to AOD.

There is long standing mistrust of health services providers by Aboriginal people because of their history of personal or family and community experience. In addition the experience of some Aboriginal people is that access to AOD services may be due to a mandated requirement through child protection and justice services.

There are indications that Aboriginal people in the NBM region may regard providers of AOD services with even greater mistrust and fear, and consequently may avoid seeking assistance for emerging or long standing dependence on substances. The Penrith Neighbourhood Centre reported that racism was a primary barrier preventing access to services. The NSW Bureau of Health Information reported that NBM Aboriginal residents perceived a poorer experience of

hospitalization compared to Aboriginal people for NSW and compared to non-Aboriginal people.

Consultations with Aboriginal people and service providers identified similar concerns and strongly identified the need for more Aboriginal people to be trained to facilitate and support access to AOD treatment on behalf of others because for many Aboriginal people self-referral is not considered.

Consultation with local Aboriginal community controlled AOD service providers indicated that Aboriginal people often present for AOD treatment when they are in crisis. This was believed to be due to a range factors including longstanding substance dependence, polydrug use, intergenerational and lived trauma, At these times, Aboriginal people present with multiple problems such as drug induced psychosis, acute physical illness and justice orders. Moreover, the complexity of these problems often means that a single treatment provider is unable to provide the support and treatment that clients require and multiple transfers of care may occur. Consultations with ACCHOs and the recently established Joint NBMLHD and NBMPHN Aboriginal Advisory Committee indicate that Aboriginal AOD clients with complex needs are experiencing an unsatisfactory and circular journey among multiple service providers, as well as poor outcomes.

New information obtained from the Penrith Neighbourhood Centre in their Yarn Up conducted in 2016, identified a range of barriers related to access of services for Aboriginal people in the Penrith LGA. The study findings were consistent with preliminary analysis of community consultations undertaken by NBMPHN during September/October 2016.
The barriers to access identified were:

1. Racism
2. Cultural Safety
3. Flexibility of services
4. Stigma
5. Support for Aboriginal staff.

In August 2016 it was reported by NSW Bureau of Health Information that NBM Aboriginal people perceived a poorer experience of hospitalization compared to Aboriginal people for NSW and compared to non-Aboriginal people. Only 48% of adult admitted Aboriginal patients in NBMLHD rated the care they received in hospital as ‘very good’.

- **Investigation of issues concerning local prison population**

The prisoner population is predominantly male at 92% (compared with 49% of general adult population), and relatively young with 68% aged under 40 years (compared with 39% of the general adult population.

Aboriginal and Torres Strait Islander people are significantly over-represented in the prison population. Indigenous people represent approximately 2% of the general adult population and on 30 June 2014, represented 27% of the prisoner population.

The health of Australia’s prisoners 2015 reported the following key indicators:

- One in four (25%) were homeless in the four weeks before entering prison
- One in three prison entrants have a chronic health condition. Asthma was the most common condition.

- Three in four prison entrants are smokers which is over 5 times the rate of the general population.
- Two in three (67%) prison entrants used illicit drugs in the 12 months prior to prison.
- Two in five prison entrants drank alcohol at risky levels before prison. This was more than half for Indigenous entrants
- One in four prisoners received medication for mental health related issues while in prison.

Other key indicators for prison population:

- 49%of prison entrants have been told by a doctor, psychiatrist, psychologist or nurse, that they have a mental health disorder which may include drug and alcohol abuse is.
- 10% reported using illicit drugs while in prison with 6% reporting injecting drugs while in prison
- 7% of entrants to prison reported being on pharmacotherapy medication for opioid dependence
- 3% of prisoners in custody received medication for opioid dependence
- 8% of prison discharges on an opiate substitution program while in prison with a plan to continue after release
- 39% of prison entrants reported a high risk of alcohol-related harm in the last 12 months (measure by the AUDIT-C)
- 58% of prison discharges reported a high risk of alcohol-related harm prior to current incarceration (measure by the AUDIT-C)
- 8% of prison discharges accessed an alcohol treatment program in prison.

Stakeholder consultations (excluding Aboriginal community consultations reported elsewhere) conducted to November 2016

- Aboriginal Health and Medical Research Council NSW
- Marrin Weejali Aboriginal Corporation, Emerton
- Community Drug Action Team (CDAT) Blue Mountains, including representatives from Police youth liaison, Department of Education, Blue Mountains Council Youth Services Development and a range of service providers
- MYST (Mountains Youth Services Team)
- Dianella Cottage, Katoomba
- Family Drug Support Australia, Leura
- 180TC residential rehabilitation provider Yarramundi for men and Kurmond for women
- Adele House residential men's program Werrington and Coffs Harbour
- The Lyndon Community at Orange
- NADA
- Intensive Drug and Alcohol Program, Corrective Services NSW Department of Justice
- Penrith Neighbourhood Centres
- Koolangara Aboriginal Centre, Cranebrook
- St John of God Hospital Windsor, Hawkesbury Health Service.

- **Other activities**

The Aboriginal Advisory Committee has been established. This is a joint NBMLHD and NBMPHN committee for AOD and mental health. The role is to provide advice and guidance for the commissioning of NBMPHN targeted funds for Aboriginal people, as well as advice to

support NBMLHD program development. There are 14 positions for Aboriginal representatives who have an interest in AOD and mental health covering each of the LGAs and key Aboriginal liaison positions in the region. The committee was established 10 November and will meet monthly initially to progress immediate priorities including co-design of models for NBMPHN commissioning of services.

The AOD Advisory Group will meet for the first-time 8 December 2016. This committee membership will consist of State and Commonwealth funded services and NGOs operating in the region. Fifteen representatives are expected to attend. The terms of reference will address consultation concerning identified priorities, co-design and collaboration opportunities.

The proposed AOD Symposium will be held during 2017 with a focus on developing a regional plan for AOD in collaboration with the NBMLHD.

Section 2 – Outcomes of the health needs analysis

ALCOHOL AND OTHER DRUGS

Outcomes of the health needs analysis: Substance Use (population prevalence and risk factors)		
Identified Need	Key Issue	Description of Evidence
2.1 Increasing demand for AOD services.	Increasing use of methamphetamines reported nationally.	One key finding of the National Ice Taskforce that is of particular concern to regional planning was the increasing usage of crystalline form methamphetamine. This was reported to have more than doubled in the period between 2007 (100,000 surveyed users) and 2013 (over 200,000 surveyed users). *Final Report of the National Ice Taskforce, 2015* The National Drug Household Survey similarly reported a change in the main form of methamphetamine used with ice replacing powder. There was no significant rise in methamphetamine use in 2013 compared to 2010, reported stable at around 2.1%. The use of powder fell from 51% to 29%. At the same time the use of ice increased twofold from 22% in 2010 to 50% in the 2013 survey. *Australian Institute of Health and Welfare, National Drug Strategy Household Survey detailed report, 2013*. Increased use of methamphetamines has been associated with a range of mental health and related problems. Psychosis is one possible consequence of methamphetamine use. Dependent methamphetamine users are also known to suffer from a variety of comorbid health problems. *Department of Health and Aging, National Mental Report 2013.* The NBM region had the 3rd highest rate of methamphetamine-related hospitalisations according to NSW PHN area in 2013-14 with a rate of 53.1 per 100,000 population. The trend

Outcomes of the health needs analysis: Substance Use (population prevalence and risk factors)		
		since 2009-2010 show a substantial increase from less than 10 per 100,000 to more than 50 per 100,000. This trend is slightly higher than the average for NSW during the same period. *HealthStats NSW: Drug misuse, Methamphetamine-related Hospitalisations x PHN, 2013-14* November 2016 update: NBM region hospitalisations related to Methamphetamine have increased considerably since 2010 from a rate of 4.9 per 100,000 population to 97.1. This rate per 100,000 has been consistently higher than the NSW state which was 13.4 in 2010 and 85.5 in 2015. *Health Stats NSW accessed 11/11/16* www.healthstats.nsw.gov.au Methamphetamine represents 29% for the drug of choice in NSW with Crystal representing 21% overall. For this Illicit Drugs Reporting System (IDRS) 2016 sample Methamphetamine represented 40% of the drug injected most often in the previous month with Crystal representing 36% overall. In the previous six months of the survey, 77% of NSW participants reported using any form of methamphetamine. The median days of use in that period for NSW participants was 36.5 and crystal represented 30 days. Availability of Crystal was regarded as very easy by 61% of NSW participants. *Australian Drug Trends 2016. Findings from the Illicit Drugs Reporting System (IDRS)* Crime statistics for the NBM region indicate that Penrith LGA has higher Amphetamines use and possession compared to the state. In the twelve months up to June 2016, Penrith LGA reported 200.4 per 100,000 population compared to 131.1 per 100,000 for the state. There was a 26.3% increase over the previous two years. Other LGAs: Lithgow, Blue Mountains, Hawkesbury reported rates less than the state average. All LGAs reported possession/use rates less than the state average for use/possession of Narcotics, Cannabis, Ecstasy, Cocaine and Other Drugs. *Bureau of Crime Statistics & Research: Crime Tool. Accessed 4/11/16* *http://crimetool,boscar.nsw.gov.au/boscar/*

Outcomes of the health needs analysis: Substance Use (population prevalence and risk factors)		
2.2 Increasing complexity of AOD clients.	Polydrug use reported nationally. Complex AOD clients have become the norm.	In the National Drug Household Survey polydrug use is generally defined as the use of more than one illicit and/or substance (including tobacco and alcohol) during the previous 12 months, but not necessarily at the same time. In 2013, more than 40% of those surveyed smoked daily, drank alcohol at risky levels or used an illicit drug in the previous year. All three behaviours were reported for 3.1% of persons surveyed. Approximately half (49%) of daily smokers consumed alcohol at quantities regarded as risky. Daily smokers reported using an illicit drug at 37%. Cannabis was reported as the drug most commonly used in addition to other illicit drugs. Misuse of pharmaceuticals and synthetic cannabis was most common among cannabis users, ranging from 30% for pharmaceuticals to 91% for synthetic cannabis. People who misused pharmaceuticals along with cannabis were most likely to use only those substances. Most synthetic cannabis users also used cannabis at 91%. Among users of other psychoactive substances along with at least one other illicit drug, over 50% used cannabis, ecstasy and methamphetamines. Inhalants and other psychoactive substances were least likely to be used with other drugs. *Australian Institute of Health and Welfare, National Drug Strategy Household Survey detailed report, 2013*. NADA's submission (2013) to the NSW Parliament Legislative Council highlighted the increasing complexity of clients attending AOD treatment. They reported that complex clients are now regarded as the norm and not the exceptional client. The profile of typical clients supported by the NGO sectors was reported as: - Having more than 10 years of Polydrug dependence - A history of multiple treatment episodes - A history of multiple incarcerations and multiple psychiatric admissions (generally without clear diagnosis or treatment continuity) - Undiagnosed and/or untreated PTSD

Outcomes of the health needs analysis: Substance Use (population prevalence and risk factors)		
		- Having children removed by community services - Diagnosed with blood borne viruses - Having poor physical health including STIs - Isolated from their families and socially embedded with drug using peers - Frequently homeless - Entering treatment having used drugs during pregnancy - Not having a regular GP to support primary care - Having major dental problems - Having outstanding legal issues - A complex debt situation. *NADA. Submission to NSW Parliament Legislative Council: Inquiry into Drug and Alcohol Treatment, February 2013.*
2.3 At risk populations.	Social determinants associated with substance use and at-risk populations.	*From the National Drug Strategy Survey:* Males are considerably more likely than females to use illicit and licit substances (except pain-killers). Females were less likely to drink alcohol at risky quantities that placed them at risk of harm. Females are also more likely to participate in strategies aimed at reducing problems associated with drug use. The proportion of women consuming alcohol during pregnancy has declined and women have indicated that they tended to change their alcohol consumption when pregnant. **Aboriginal people**: High proportions of Aboriginal people smoke tobacco, use alcohol at risky levels, use cannabis and methamphetamines when compared to non-Aboriginal people according to results of the survey. Aboriginal people are also twice as likely to use cannabis compared to non-Aboriginal people. **Refer to specific section describing drug and alcohol use among Aboriginal people.** **Remote & Regional**: People who live in remote and very remote areas were reported as more likely to smoke, drink alcohol at risky levels, use cannabis and methamphetamines.

Outcomes of the health needs analysis: Substance Use (population prevalence and risk factors)		
		However, people who live in remote and very remote areas were less likely to use illicit drugs such as cocaine and ecstasy compared with people living in major cities. **Socioeconomic status**: people living in areas with low socioeconomic status (SES) were 3 times more likely to smoke compared to people in the highest SES. They also consumed less alcohol at risky levels and used less ecstasy and cocaine than those with high SES rates. **Unemployment**: Unemployment represents a major risk factor for substance use and the development of substance-use disorders. Illicit drug use was more prevalent among people who were unemployed. They were 1.6 times more likely to use cannabis, and 2.4 times more likely to use methamphetamines. They were also 1.8 times more likely to use ecstasy, compared to people who were employed. **Mental illness**: There is a relationship between drug use and poor mental health however it is not clear the extent to which drug use causes mental health problems and to what extent mental health programs gives rise to drug use. The later often occurs in the context of self-meditation. Almost twice as many recent illicit drug users (21%) compared to non-illicit drug users (12.6%) have been diagnosed with, or received treatment for a mental illness. Illicit drug users were more likely to report high and very high levels of psychological distress in the month prior to the survey (17.5% compared with 8.6%). Use of alcohol and daily smoking were also linked to higher reports of mental illness or psychological distress. **Refer also to Comorbidity with mental disorders.** **LGBTI groups:** measured by survey includes people who identified as homosexual or bisexual. Overall this group consumed alcohol in risky quantities, smoked tobacco daily, used illicit drugs and misused pharmaceuticals at higher rates than those of the heterosexual population. The largest differences reported were for use of ecstasy and methamphetamines which was 5.8 times and 4.5 times greater than for heterosexual people. Cannabis was 2.9 times greater and cocaine use 2.8 times greater than for heterosexual people.

Outcomes of the health needs analysis: Substance Use (population prevalence and risk factors)		
		Australian Institute of Health and Welfare, National Drug Strategy Household Survey detailed report, 2013.
2.4 Substance and drug use: major categories	Trends in substance and drug use.	It was estimated in 2010 that 2.6% of the total burden of disease and 0.5% of deaths can be attributed to illicit drug use. Around 1 in 7 (15%) people have used an illicit drug in the previous 12 months. Cannabis and methamphetamine users surveyed were more likely to use these drugs on a regular basis with 64% of cannabis using at least every few months and 52% of methamphetamine users. The data below compares the 2013 National Drug Household Survey with the approximate primary drug of concern in NSW NGO's providing treatment services for substance use. - **Alcohol**: The survey lifetime risk of harm from alcohol use is 18.2% and has declined significantly in recent years from 20.5%. In 2013 alcohol was the main drug of concern to household survey respondents at 42.5% with a median age of 48 years. 6.5% reported they drank at risky levels on a daily basis. o Alcohol use as the primary concern represents 38.1% as the highest reason for seeking treatment. NGO's also report an increase in alcohol use. o Rates of alcohol attributable deaths in the NBM PHN area were 16.5 per 100,000 population. This was the ranked fifth among all NSW PHNs and the highest among metropolitan based NSW PHNs. o Alcohol attributable hospitalisations for the NBM PHN in 2013-2014 were 814.6 per 100,000 population, compared with 687.9 per 100,000 population for all NSW PHNs. This is the highest rate among NSW PHNs. - **Cannabis**: Survey use of cannabis was 10.2% and the highest proportion among illicit drugs. 3.8% of survey respondents ranked cannabis as the drug of most serious concern. 45.4% of respondents used monthly or more and 81.9% used with alcohol. Males are more likely to use cannabis.

Outcomes of the health needs analysis: Substance Use (population prevalence and risk factors)		
		Cannabis represented 18% of the surveyed population and third ranking drug of concern among NSW NGO's. - **Methamphetamine**: Survey use of methamphetamine was 2.1% and showed some decline from earlier surveys. In 1998 methamphetamine use was reported at 3.7%. 16.1 % of respondents ranked methamphetamine as the drug of most serious concern. The median age was 31 years, 66.5% used with alcohol and 32.1% used monthly or more. Males are more likely to use methamphetamines and the age group of users is increasing from 24 in 2001 to 28 in 2013. The age of first use was 18.6 in 2013. Methamphetamine was second ranking drug of concern among NSW NGOs at 22.2%. NADA also reported an increase in client complexities and usage related to methamphetamine. - **Ecstasy** was the second most commonly used illicit substances during a person's lifetime at 2.5% of the population. The majority of users took ecstasy once or twice a year at 54% and the median age was 25 years. - **Heroin** represented 0.1% of the surveyed population and 11% as the primary drug of concern for NGOs. - **Pharmaceuticals for non-medical purposes** represented 2.2% of the drug of most serious concern for survey respondents. The average age was 46 years and 32.3% used with alcohol. This group showed the largest increase of all drug types surveyed at 7.7% in 2013 compared to 4.8% in 2010. The proportion who had ever misused a pharmaceutical drug increased to 11.4% in 2013 from 7.4% in 2010, 4.7% of respondents over 14 years has misused a pharmaceutical in the previous 12 months. Paracetamol was the most common type among the over-the-counter drugs, followed by ibuprofen and codeine combination products. People aged between 20-19 years at 5.8% and between 30-39 years at 5.3% were most likely to have misused pharmaceuticals in the previous 12 months. Pain killers were mostly commonly

Outcomes of the health needs analysis: Substance Use (population prevalence and risk factors)		
		misused and these were primarily over-the-counter analgesics compared with prescription analgesics. - **Emerging psychoactive substances (EPS)**: These are drugs with mind-altering effects and relatively new to the recreational drug market. EPS generally mimics the effects of other illicit psychoactive drugs including cannabis, ecstasy and hallucinogens. Indications for usage are likely to be under reported due to the rapid rate at which new chemical formulas are developed. The most likely age groups using synthetic cannabis is 14-19 years at 2.8% followed by people between 20-29 years at 2.5%. The most likely group to have used other psychoactive substances is people between 20-29 years at 1.3%. In addition to increases in methamphetamine use, NADA reported increased use of 'harder' drugs other than heroin in adults. *Australian Institute of Health and Welfare, National Drug Strategy Household Survey detailed report, 2013*. *Network of Alcohol and Other Drugs Agencies (NADA), A Planning Tool for NGO Alcohol and Other Drugs Treatment Services, March 2016*. *NADA, Responding to alcohol and drug related harms in NSW, November 2014.*
2.5 Substance use in young people.	National trends, factors associated with substance and drug use in youth and local reports of substance and drug use by youth.	Adolescence is commonly regarded as a period of rapid physical and psychological transition with experimentation and risk-taking behaviours. This may include illicit drug use with associated short and long term health and other problems. People who initiate drug use early are at greater risk of future illicit and problematic drug use. Young people show a declining rate of smoking uptake. The proportion of youth aged 12-17 who have never smoked was high at 95%, and those aged 18-24 also show decreasing uptake with those reporting never smoking at 77% compared to 58% in previous survey. Overall smoking is declining according to uptake and numbers of people who smoke daily.

Outcomes of the health needs analysis: Substance Use (population prevalence and risk factors)		
		Younger people also appear to be choosing to abstain from alcohol with those between 12-17 years abstaining at a rate of 72% compared with 64% in previous surveys. Alcohol consumption rates did not show changes between surveys. Comparative Household Survey data indicates that substance use among 14-29 year olds has declined over time. - Risky drinking was 47% in 2001 and declined to 42% in 2010. Risky drinking is higher among 20-29 year olds than for 14-19 year olds. People in their late teens and 20s were more likely to consume 11 plus standard drinks compared to people in all other age groups. The average age at which you people first tried alcohol was 15.7 in 2013. - The age when people first tried an illicit drug was 19.4 in 2013. Among those aged between 14-24 years, the age of initiation into illicit substances was 16.3 in 2013. - Use of amphetamines was 10% in 1998 and reduced to 4% in 2010. - Cannabis is the most commonly used illicit drug across all age groups however cannabis users were more likely to first try cannabis in their teens. There are indications that cannabis use precipitates psychotic symptoms, as well as exacerbate the symptoms of schizophrenia. Cannabis use also increases the risk of later depression and suicide. The main substances that are regarded as contributing to mental illness in young people are alcohol, cannabis and methamphetamine. *Department of Health and Aging, National Mental Report 2013.* *Australian Institute of Health and Welfare, National Drug Strategy Household Survey detailed report, 2013*. In 2009, the Mountains Youth Services Team (MYST) undertook detailed analysis of issues around the mental health of young people in the Blue Mountains LGA. The study reported that substance use by young people was a significant mental health issue, particularly in regard to comorbidity with substance use. The study pointed to a high prevalence of depression among Blue Mountains young people. The report considered that alongside

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<tr><th colspan="3">Outcomes of the health needs analysis: Substance Use (population prevalence and risk factors)</th></tr>
<tr><td></td><td></td><td>preconditions for cannabis use, a high priority need for effective early intervention services was strongly indicated.
Mountains Youth Services Team, Blue Mountains Youth Mental Health Study, 2009.

Another Blue Mountains study (Project Skylight) in 2010 reviewed alcohol use in the LGA and reported that young people were impacted significantly by alcohol use with binge drinking rates in young males well above the NSW average.

This study consulted extensively with service providers throughout the Blue Mountains LGA and reported that:
- Providers of youth and family support services (State and NGOs) confirmed the prevalence of alcohol use among young people. Of considerable concern was binge (high risk) drinking among young people, the social consequences, some of which included violence, sexual assault, unsafe sex, malicious damage, school failure and unemployment.
- Stakeholders described the prevalence of cannabis use along with poly drug use mixing alcohol and cannabis use, and alcohol in conjunction with ecstasy and other drugs.
- Service providers working with young people identified alcohol as the substance of choice for males who were under 24 years of age. Girls between 14-16 years were identified as more likely to choose alcohol as the primary substance in contrast to 17-18 year olds who were more likely to use cannabis. Particular concerns were expressed in relation to the Upper Mountains (Blackheath and Mount Victoria) where there were fewer transport options and fewer options for socializing and entertainment.

Project Skylight (2010) conducted a focus group with a small group (5) of students and teachers (3) from the Lawson Campus of Blacktown Youth College. The College provides an alternative School Certificate program for at risk students aged 15-16 years. These students typically came from unstable family situations including violence and substance abuse, homeless or involved with juvenile justice. Some key findings from this groups were:</td></tr>
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Outcomes of the health needs analysis: Substance Use (population prevalence and risk factors)		
		- Unwillingness to seek help from authority figures such as general practitioners and police - Expressed mistrust of psychiatrists and counsellors based on their own experiences - Willingness to trust youth workers from a local youth centre - Emphasized the interconnectedness of substance abuse with grief and trauma - Related the onset of their substance dependence and that of family members to traumatic events including childhood sexual abuse, suicide of a family member, and the death of a child. - Raised issues concerning intergeneration substance misuse in families and their predisposition to substance dependence. *Project Skylight - Blue Mountains Drug and Alcohol Recovery Services Inc., Report 2: Alcohol and other drugs in the Blue Mountains, 2010.*

2.6 Substance use presentations to general practice and community centres.	Feedback from consultations with general practice and neighbourhood centre managers.	A survey conducted in 2010 of 19 general practitioners (primary health care) and Neighbourhood Centre managers (community services) by Project Skylight was undertaken in the Blue Mountains LGA and reported the following:
		- Only a small proportion of patients presented with AOD issues as their primary health concern although a significant proportion had an underlying problem with substance use.
		- Alcohol was identified as the most prevalent problem substance, followed by benzodiazepines and other prescription drugs, and cannabis.
		- GPs identified young people and people with dual diagnosis as the groups most in need of services.
		- Centre managers identified young people as those most in need of AOD services.
		- There were differences between the Upper and Lower Mountains:
		  o Substance use was more common among the 30-50 year old group in Upper Mountains
		  o Substance use was common in 20-40 year old group in Lower Mountains.
		- Substance use was prevalent among disadvantaged clients and their families.

Outcomes of the health needs analysis: Substance Use (population prevalence and risk factors)		
		- The groups identified as highest priority by service providers were women with children; young people, particularly those from disadvantaged families; people with dual diagnosis and Aboriginal people. *Project Skylight - Blue Mountains Drug and Alcohol Recovery Services Inc., Report 2: Alcohol and other drugs in the Blue Mountains, 2010.*
2.6.1 Priorities identified in Blue Mountains 2010 community consultations.	Barriers to effective service provision and community priorities.	Community consultations in 2010 conducted under Project Skylight involved community forums, individual interviews and a focus group with young people. **Refer to substance use in young people for results of community consultations.** Blue Mountains residents who were regarded as needing AOD treatment or support most were (not in order of priority) young people; single mothers; people on methadone; men; and, families. The biggest problem substances in the Mountains were firstly alcohol and secondly cannabis. The main barriers people encountered when trying to deal with drug and alcohol problems were: - Denial - Lack of information - Fear of losing children - Access and transport problems - Lack of choice in type of service - Shame - Fear of withdrawal - Waiting lists - Unwillingness to join self-help groups - Peer pressure to use substances. The kind of services that people wanted or needed were: - Flexible counselling to support attitude change over a longer term - More GPs with skills and understanding of addiction issues

Outcomes of the health needs analysis: Substance Use (population prevalence and risk factors)		
		- Day centre offering support and activities - Crisis accommodation - Information about needle exchange programs - More community support for men - Case management - Exit strategies for people on methadone programs - Soft entry programs such as outreach - Education for prevention. A mix of access was identified with location based services together with central telephone intake and referral, as well as effective website access to services. *Blue Mountains Drug and Alcohol Recovery Services Inc., Report 2: Alcohol and other drugs in the Blue Mountains, 2010.*
2.7 Characteristics of substance and drug users: local and national.	Apparent high prevalence of illicit drug use supported by prevalence of drug related crime.	2014 crime statistics indicate that Hawkesbury and Blue Mountains LGA report drug related crime below the state average. Penrith LGA is higher than state averages for amphetamine use or possession at 121.8 per 100,000 population compared to 95.2 per 100,000 for the state. Ecstasy use or possession was also higher at 58.5 per 100,000 population compared to 37.6 per 100,000 for the state. Lithgow LGA reported the highest rates of cannabis use or possession at 312.5 per 100,000 population, when compared to the other LGAs in the region. Amphetamine use or possession for Lithgow LGA was 118.4 per 100,000 population and higher than the state average of 95.2 per 100,000 population. *NSW Bureau of Crime Statistics and Research, 2014* Regional rates for the possession or use of amphetamines were higher for the Outer Western and Blue Mountains region (132.8 per 100,000 population) when compared to greater

Outcomes of the health needs analysis: Substance Use (population prevalence and risk factors)		
		Sydney and the state (110.7 per 100,000 population and 118.1 per 100,000 population respectively). *NSW Bureau of Crime Statistics and Research, 2014.* Reference: sr15-13513 National Household Survey 2013 indicates that one in five people smoked and used alcohol at risky levels or used illicit drugs. These rates double in remote areas. Based on 2011 census data, more than 70,000 people in the NBM region may be involved in risky use of tobacco, alcohol and drugs. During 2013, cannabis the most common of illicit drugs used with 10% of the population over 14 years of age reporting use in the previous 12 months and 35% reporting lifetime use. Cannabis and amphetamine users are more likely to use every months at 64% and 52% respectively. *National Drug Strategy Household Survey detailed report, 2013* NBM primary care providers report presentations and referrals for drug and alcohol services in relation to: - Often the first contact with the primary care provider is through the family seeking advice regarding another family member - Cannabis is the leading drug use. This cohort ranges from long term heavy use to recreational use. Long term users were often regarded as using to self-medicate (possibly 20-30%). - Users of ICE rarely attended primary care providers. Those that attend are young to middle aged. - Abuse of prescription and other medications - Young people are the main group presenting with issues concerning drug use. *NBMPHN Preliminary Mental Health and Drug and Alcohol Stakeholders. 2016*
2.7.1 Characteristics of substance and drug users: local and national.	Apparent high prevalence of risky alcohol use supported by prevalence of alcohol related crime.	Alcohol is consumed widely in Australia and harmful levels of consumption are a major health issue associated with increased risk of chronic disease, injury and premature death. *National Drug Strategy Household Survey detailed report, 2013*

Outcomes of the health needs analysis: Substance Use (population prevalence and risk factors)		
		Blue Mountains and Lithgow LGAs reported the highest levels of crime involving alcohol. For the Blue Mountains robbery related to alcohol involved 35% of all robberies compared to 19.3% for the state. Lithgow LGA reported domestic violence involving alcohol at 34% compared to 33.4% for the state. Assault involving alcohol was 38.1% compared to 36.6% for the state. Notably, robbery involving alcohol was 42.9% compared to 19.3% for the state. NBM primary care providers identified alcohol as a substance use problem across all ages. This included alcohol abuse and addiction, often requiring medicated detoxification support. Longer term users were often regarded as using to self-medicate (possibly 20-30%). *NBMPHN Preliminary Mental Health and Drug and Alcohol Stakeholders. 2016*
2.8 Characteristics of substance and drug users: local and national.	Indications of prevalence of misuse of prescription medications.	Misuse of pharmaceutical medications has increased from 4.2% in 2010 to 4.7% in 2013, according to the National Drug Strategy Household Survey. *National Drug Strategy Household Survey detailed report, 2013* NBMPHN preliminary stakeholder consultations with NBM primary care providers indicate prevalence of abuse of abuse of prescription medications. *NBMPHN Preliminary Mental Health and Drug and Alcohol Stakeholders. 2016*
2.9 Characteristics of substance and drug users: local and national.	Prevalence of mental health and drug and alcohol diagnosis (dual diagnosis)	Illicit drug use is a major risk factor for mental illness, suicide, self-inflicted harm and drug overdose. There is a strong association between illicit drug use and mental health issues. In the context of self-meditation, it is difficult to isolate to what degree drug use causes mental health problems, or to what degree mental health problems give rise to drug use. People using meth/amphetamines in the past 12 months were more likely than any other drug users to report diagnosis or treatment for a mental illness at 29% compared to 13.5% for non-users. People using methamphetamines also report greater levels of high or very high psychological distress at 27% compared with 9.6%.

Outcomes of the health needs analysis: Substance Use (population prevalence and risk factors)		
		The rate of mental illness almost doubles with illicit drug use. Almost twice as many recent illicit drug users (21%) compared with non-illicit drug users (12.6%) have been diagnosed with, or treated for mental illness. Illicit drug users reported being more likely to experience high or very high levels of psychological distress in the four weeks before participating in the National Drug Strategy Household Survey (NDSHS) (17% compared with 8.6%). *National Drug Strategy Household Survey detailed report, 2013* NBM PIR clients with complex and severe mental illness report high prevalence of comorbidity with drug use. *NBM PIR Program* NBMLHD Drug and Alcohol regional planning has prioritised treatment of co-morbid conditions in mental health and drug and alcohol treatment alongside new models of integrated care that support: Whole of Family Teams; and co-located service provision. *NBMLHD Drug and Alcohol Draft Regional Plan 2016* Consultations undertaken by Project Starlight 2010 reported a strong theme from interviews with service providers concerning the interrelationship of substance use and mental health issues. Some respondents reported that 50% of their current client group (mostly men between 16-26 years) were dual diagnosis, with anxiety as the most common mental health issue. It was noted that clients with complex chronic conditions and psychosis were more likely to be referred to the Mental Health Team than AOD counsellors. A prevalence of trauma histories amongst clients who are substance users was also reported. One psychologist reported that among people attending the local methadone program approximately 60-70% of clients had a diagnosis of borderline personality disorder, post-traumatic stress disorder, dissociative identity disorder considered to be outcomes of childhood histories of neglect and physical and/or sexual abuse. *Project Skylight - Blue Mountains Drug and Alcohol Recovery Services Inc., Report 2: Alcohol and other drugs in the Blue Mountains, 2010.*

Outcomes of the health needs analysis: Substance Use (population prevalence and risk factors)		
2.10 Characteristics of substance and drug users: local and national.	Prevalence of health disorders among alcohol and drug users reflected in shorter than average life expectancy.	Alcohol is consumed widely in Australia and harmful levels of consumption are a major health issues associated with increased risk of chronic disease, injury and premature death. *National Drug Strategy Household Survey detailed report, 2013* Studies have shown that chronic substance users have a shorter life expectancy compared to the general population, of approximately 15-20 years. NBMLHD has identified co-existing physical disorders as a major contributor to early death among chronic substance users. There is an increasing need for drug and alcohol services to address a range of comorbid physical health including diabetes, circulatory diseases, blood borne viruses, as well as mental health, depression and neurocognitive deficit disorders. This population group have poor access to preventative health services and high rates of admission to hospital for a range of health issues, in addition to drug and alcohol use. *NBMLHD Drug and Alcohol Service Planning Consultation, 2016.*
2.11 Characteristics of substance and drug users: local and national.	Prevalence of socioeconomic disadvantage and high risk groups.	Studies have found clear links between socioeconomic disadvantage and the risk of dependence on alcohol, nicotine and other drugs. In Australia the high risk population groups are: socioeconomically disadvantaged, those living in rural and remote areas, Aboriginal people, pregnant women, the unemployed, people who identify as homosexual or bisexual, people with mental illness and those with high levels of psychological distress. *National Drug Strategy Household Survey detailed report, 2013* Refer also to Socioeconomic Disadvantage and Equity for details of levels of disadvantage within the NBM region. In summary: - Penrith LGA reflects wide disparities of advantage and disadvantage. The most disadvantaged areas were in Cranebrook; South Penrith; Kingswood; Cambridge Park; and St Marys. - Blue Mountains LGA reflects relative advantage among the broader population with pockets of extreme disadvantage in Katoomba. - Hawkesbury LGA reflects relative advantage among the broader population. Extreme disadvantage has been identified in South Windsor.

Outcomes of the health needs analysis: Substance Use (population prevalence and risk factors)		
		- Lithgow LGA broadly reflects high levels of disadvantage with extreme pockets of disadvantage in Bowenfels, Hermitage Flat, Vale of Clwydd, Cullen Bullen. *NBMLHD: Socio-economic Indexes For Areas of NBMLHD in 2011 Census.*
2.12 Risk Factors	Identified risk factors for mental illness include alcohol and drugs.	In the most recent Australian Burden of Disease study the leading attributable risk factors in mental disorders were found to be the harmful effects of alcohol (9.7% of attributable burden), illicit drugs (8%), child sexual abuse (5.8%) and intimate partner violence (5.5%). *Begg S, Vos T, Barker B. The burden of disease and injury in Australia, 2003. Cat. no. PHE 82 edition. Canberra: AIHW, 2007 cited in NBMLHD Epidemiological Profile: Mental Ill Health. 2014*
2.13 High risk populations	Release from regional correctional facilities.	Consultations to date indicate that inmates released from correctional facilities in the region are at high risk of harmful substance use. There are also suggestions that inmates who have undergone drug treatment have difficulty receiving necessary support services to maintain abstinence or low risk substance use on release. Further research is required to establish any links between the number of correctional facilities, inmates released and needs that may be relevant to AOD treatment provision in the region. NSW inmates census data appears to be no longer published. The most recent report was for 2014. This 2014 publication reports the following data that may be relevant to NBM region. There are four adult and one juvenile correctional facilities: - Lithgow maximum security for men reporting 420 inmates. 67 or 16% were Aboriginal men during that period. Dillwynia medium and minimum correctional facility for women reporting 215 inmates. 67 or 31% were Aboriginal women during that period. - John Morony & Dillwynia facilities (co-located at Berkshire Park) reporting 479 inmates. 64 or 13% were Aboriginal men and women during that period. - Emu Plains minimum security for women reported 187 inmates. 49 or 26% were Aboriginal women during that period.

Outcomes of the health needs analysis: Substance Use (population prevalence and risk factors)		
		- Cobham juvenile remand centre for young men at St Marys. No data was reported for this facility. The statistical area of last known address reported in 2014 indicates that inmates from the NBM region represented approximately 4.6% of the prison population and 491 inmates, from the location categories: Baulkham Hills and Hawkesbury; and, Outer West and Blue Mountains. *NSW Justice Corrective Services. Statistical Publication. NSW Inmate Census 2014.*
2.14 Prison population risks	Health of Prisoners	The prisoner population is predominantly male at 92% (compared with 49% of general adult population), and relatively young with 68% aged under 40 years (compared with 39% of the general adult population. Aboriginal and Torres Strait Islander people are significantly over-represented in the prison population. Indigenous people represent approximately 2% of the general adult population and on 30 June 2014, represented 27% of the prisoner population. The health of Australia's prisoners 2015 reported the following key indicators: - One in four (25%) were homeless in the four weeks before entering prison - One in three prison entrants have a chronic health condition. Asthma was the most common condition. - Three in four prison entrants are smokers which is over 5 times the rate of the general population. - **Two in three (67%) prison entrants used illicit drugs in the 12 months prior to prison.** - **Two in five prison entrants drank alcohol at risky levels before prison. This was more than half for Indigenous entrants** - One in four prisoners received medication for mental health related issues while in prison. Other key indicators:

Outcomes of the health needs analysis: Substance Use (population prevalence and risk factors)		
		- The proportion of prison entrants who have ever been told by a doctor, psychiatrist, psychologist or nurse, that they have a mental health disorder which may include drug and alcohol abuse is 49%. - 10% reported using illicit drugs while in prison with 6% reporting injecting drugs while in prison - 7% of entrants to prison reported being on pharmacotherapy medication for opioid dependence - 3% of prisoners in custody received medication for opioid dependence - 8% of prison discharges on an opiate substitution program while in prison with a plan to continue after release - 39% of prison entrants reported a high risk of alcohol-related harm in the last 12 months (measure by the AUDIT-C) - 58% of prison discharges reported a high risk of alcohol-related harm prior to current incarceration (measure by the AUDIT-C) - 8% of prison discharges accessed an alcohol treatment program in prison. In 2015, methamphetamine was the most commonly reported illicit drug used by 50% of prisonentrants as having used this drug in the previous 12 months. 41% reported using cannabis. Prescription medications was the third most commonly reported drug. 13% of entrants reported illicit use of analgesics or painkiller and 11% reported illicit use of tranquilizers or sleeping pills. 9% reported using heroin and 7% ecstasy during the previous 12 months. Use of these substances was similar for males and females except for illicit use of analgesics and tranquillizers. Women reported 27% compared to 11% for men concerning analgesics, and 26% compared to 9% for men concerning tranquillizers. Indigenous entrants appear less likely to use methamphetamine compared to non-Indigenous entrants at 38% compared to 54%.

Outcomes of the health needs analysis: Substance Use (population prevalence and risk factors)		
		The highest usage rates by age group was the 18-24 year entrants with 53% for cannabis and 59% for methamphetamine. Entrants reporting that they were receiving methadone through opioid substitution programs was 47% and this dropped to 28% for prison discharges which may indicate that access to methadone among the prison population is more restricted. Risky alcohol consumption is strongly linked to a range of adverse psychosocial outcomes that affect health and mental health including family violence, relationship instability, sexual risk-taking and consequences, unemployment, violence victimization and criminal offending. Alcohol was consumed at risky levels by 39% of prison entrants during the previous 12 months. Low risk drinkers represented 27%. Indigenous entrants were the group most likely to be at risk of alcohol related harm. 54% reported risky drinking compared with 33% of non-Indigenous entrants. Young men (18-24) reported the highest percentage of more than 7 drinks on a usual day of drinking at 41%, compared to 35% for both 25-35 years and 35-44 years. *AIHW. The health of Australia's prisoners, 2015*

Alcohol and Other Drugs: Aboriginal people

Outcomes of the health needs analysis – Substance Use (Aboriginal people)		
Identified Need	Key Issue	Description of Evidence
2.13 Population characteristics.	High proportion of Aboriginal people living in NBM region, compared to proportion of population for other metropolitan health districts.	NBMLHD reports that in 2011, the population who identified as Aboriginal comprised 2.5% of the total population, representing 8.827 people. This represents 5.32% of the NSW population of Aboriginal people. As a proportion of the total population, NBM region reports the highest among the eight NSW metropolitan LHDs. *Epidemiological Profile of NBMLHD, 2014* Lithgow LGA had the highest proportion of Aboriginal residents and lowest number of Aboriginal people at 703, representing 3.4% of the total Lithgow population. Penrith LGA had the highest number of Aboriginal residents at 5,351. Hawkesbury LGA reported 1,513 Aboriginal residents and 2.4% of the total Hawkesbury population. Blue Mountains LGA reported 1,259 Aboriginal residents and 1.6% of the total Blue Mountains population. Indigenous population estimates across Australia are widely regarded as underestimated. There was a 30% increase in the estimate of the Indigenous population across Australia between the 2006 and 2011 Censuses. *Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report* Local consultations with Aboriginal people and staff involved in the Close The Gap and Healthy For Life programs suggest that the current population estimates for the NBM region are substantially underestimated due to reluctance of some Aboriginal people to formally acknowledge their identity. *NBMPHN workforce consultations, 2015*
2.14 Population characteristics.	NBM region is made up three different Aboriginal Nations as identified by traditional lands and language.	There is considerable diversity of Aboriginal peoples in the NBM region. There are three Aboriginal nations represented in the NBM region that roughly equate to our LGAs. The people of the Nepean and Hawkesbury LGAs are living on the land of the Dharug

Outcomes of the health needs analysis – Substance Use (Aboriginal people)		
		people. The Blue Mountains roughly equates to the land of the Gandangara people. The Lithgow LGA is part of the Wiradjuri peoples land which extends through central NSW. *NBM Aboriginal Sharing and Learning Circles, Blue Mountains LGA, Hawkesbury LGA, Penrith LGA, Lithgow LGA, 2015*
2.15 Population characteristics.	Young and growing population of Aboriginal residents in NBM	The median age of Aboriginal residents in the region was 21 years in 2011. NBM Aboriginal people under 25 years of age represent 55.5% of the total Aboriginal population, compared to 35.5% of people under 25 years of age in the non-Aboriginal population. The age group 15-19 years is the largest percentage of the population at 12.3%. *Epidemiological Profile of NBMLHD, 2014*
2.16 Population characteristics.	Aboriginal people have poorer socio-economic status compared to non-Aboriginal people	Selected socioeconomic indicators from the 2006 Census demonstrate the relative disadvantage in NSW of the Aboriginal population when compared with the non-Aboriginal population. In NSW, and compared with the non-Aboriginal population - larger percentages of Aboriginal people were: unemployed; had no post-school qualifications; had no household internet connection; had a weekly household income less than $500; rented housing; lived in multi-family households; and resided in dwellings with 7 or more people. Of these the largest categories of disparity were: unemployment, no post-school qualifications and rental accommodation. *Epidemiological Profile of NBMLHD, 2014*
2.17 Population characteristics.	NBM Aboriginal residents have a higher prevalence of smoking compared to non-Aboriginal people.	2011-12 hospitalisation rates that may be attributed to smoking show that Aboriginal people have a rate of 1,263 hospitalisations per 100,000 population, compared to 550 per 100,000 for non-Aboriginal residents admitted to hospital. *Epidemiological Profile of NBMLHD, 2014*

Outcomes of the health needs analysis – Substance Use (Aboriginal people)		
2.18 Population characteristics.	NBM Aboriginal people experience a significantly higher rate of hospitalisation that is attributable to alcohol, compared to non-Aboriginal people.	2011-12 rates of hospitalisation attributable to alcohol for the NBMLHD shows that Aboriginal people have a rate of 1082.5 hospitalisations per 100,000 population. The rate for non-Aboriginal people was 731.3 hospitalisations per 100,000. *Epidemiological Profile of NBMLHD, 2014*
2.19 Substance use.	Prevalence of drug use in Aboriginal communities.	Overall Indigenous Australians were more likely to abstain from drinking alcohol than non-Indigenous Australians (28% compared with 22% respectively). However among those who did drink alcohol, risky drinking levels represented a higher proportion. Excluding ecstasy and cocaine, Indigenous Australians use illicit drugs at a higher rate than the general population. In 2013, Indigenous Australians were: 1.6 times more likely to use any illicit drug in the previous 12 months; 1.9 times more likely to use cannabis; 1.6 times more likely to use meth/amphetamines; and 1.5 times more likely to misuse pharmaceuticals, compared to non-Indigenous people. These differences were still apparent after adjusting for differences in age structure of both populations. There were no significant changes in illicit drug use among Indigenous Australians between 2010 and 2013. *National Drug Strategy Household Survey detailed report, 2013* Preliminary consultation with Aboriginal stakeholders indicate: - NBM Aboriginal residents are generally reluctant to discuss drug and alcohol uses due to shame and fear of stigma. The importance of working with a trusted service provider who can take the necessary time to discuss how the person is feeling has been emphasised. - Barriers to access include a lack of culturally safe drug and alcohol services for Aboriginal residents. - Prevalence of cannabis use and emerging problems with use of meth/amphetamines among Aboriginal communities in the region. - The need for outreach services into Aboriginal NGOs in the region. *NBMPHN Preliminary Stakeholder Consultations for Drug and Alcohol, 2016*

Outcomes of the health needs analysis – Substance Use (Aboriginal people)		
		NBM Aboriginal Sharing and Learning Circles identified drug and alcohol issues as a priority. The concerns raised across four LGAs were: - High risk of substance use among a younger population. Approximately 55% of NBM Aboriginal people are under 25 years of age - The need for early intervention to reduce harm from alcohol and drugs - There is a high prevalence of cannabis use - The need for more Aboriginal health workers in the region to be trained to provide support for drug and alcohol issues - Access to culturally relevant information about alcohol and drugs - The need for an Aboriginal detoxification unit. *NBM Aboriginal Sharing and Learning Circles, Blue Mountains LGA, Hawkesbury LGA, Penrith LGA, Lithgow LGA, 2015.*
2.20 Aboriginal People And Mental Health	A high proportion of Aboriginal and Torres Strait Islander people experience psychological distress.	In 2012-13 in the Sydney-Wollongong area 27.3% of adult Aboriginal and Torres Strait Islander males and 41.9% of adult Aboriginal and Torres Strait Islander females were found to have high or very high levels of psychological distress. Rates of high/very high psychological distress were significantly higher for women than men in every age group, apart from those aged 45–54 years. Aboriginal and Torres Strait Islander people aged 18 years and over were 2.7 times more likely than non-Indigenous people to have experienced high/very high levels of psychological distress (age standardised). This pattern was evident for men and women across all age groups. *Australian Bureau of Statistics. (2013). Australian Aboriginal and Torres Strait Islander Health Survey: First Results, Australia, 2012-13. ABS Cat. No. 4727.0.55.001. Canberra, ACT: Australia.*
2.21 Aboriginal People: Mental Health, Drug & Alcohol	Substance abuse is a high risk factor for development of mental disorders in Aboriginal communities.	One-third of the burden of disease and injury due to mental disorders amongst Aboriginal and Torres Strait Islander peoples may be attributable to illicit drugs.

Outcomes of the health needs analysis – Substance Use (Aboriginal people)		
		Vos T, Barker B, Stanley L, Lopez AD 2007. The Burden of Disease and Injury in Aboriginal and Torres Strait Islander peoples 2003, School of Population Health, The University of Queensland, Brisbane The use of illicit drugs is relatively high. In 2012/13 22% of Aboriginal and Torres Strait Islander people aged 15 years and over said that they had used an illicit substance in the previous year, and a further 23% at some other time in their life. Males were significantly more likely than females to have used an illicit substance in the previous year (27% compared with 18%), and before then (25% compared with 21%). Rates of recent illicit substance use were fairly consistent across age groups: 15–24 years (28%), 25–34 years (27%) and 35–44 years (23%), before decreasing to 19% for 45–54 years and 7% aged 55 years and over. *Australian Bureau of Statistics. (2013). Australian Aboriginal and Torres Strait Islander Health Survey: First Results, Australia, 2012-13. ABS Cat. No. 4727.0.55.001. Canberra, ACT: Australia*
2.21.1	High prevalence of methamphetamine use.	In 2013-14 the population rate of methamphetamine-related hospitalisation amongst Aboriginal males was approximately 6 times higher than non-Aboriginal males. Among Aboriginal females, the rate was just under 8 times higher. *Crystalline Methamphetamine Background Paper – NSW Data, September 2015 (Revised), NSW Ministry of Health 2015, retrieved from http://www.healthstats.nsw.gov.au/IndicatorGroup/publications*
2.22	Local barriers to accessing services.	Nepean Community Neighbourhood Centres, funded by NBM Partners in Recovery, conducted a Yarn Up based on the Collective Impact Model identified barriers to culturally appropriate mental health services. The findings of this study are relevant to an understanding of AOD treatment barriers in NBM region. Barriers were: 1. Racism

Outcomes of the health needs analysis – Substance Use (Aboriginal people)		
		2. Cultural Safety 3. Flexibility of services 4. Stigma 5. Support for Aboriginal staff. Barriers perceived by the group included lack of resources, an unwillingness to learn and be educated from non-Aboriginal staff and community, ignorance, inflexibility of services, resourcing issues, perceptions about what an Aboriginal person should sound like and a lack of cultural pride. *Nepean Community & Neighbourhood Services, and NBM Partners in Recovery (June 2016) Yarn Up Report.* Patient perspectives among Aboriginal people admitted to hospital in the NBM region in August 2016 were reported by NSW Bureau of Health Information. Overall this report indicates that NBM Aboriginal people perceived a poorer experience of hospitalization compared to Aboriginal people for NSW and compared to non-Aboriginal people. In NBMLHD Aboriginal patients were less positive than non-Aboriginal patients by 10+ percentage points for more than a third of the survey questions (19 questions). Only 48% of adult admitted Aboriginal patients in NBMLHD rated the care they received in hospital as 'very good'. This was the lowest proportion in NSW. Key areas of difference concerned whether Aboriginal people felt they were given enough privacy when examined or treated and whether they 'always' got the opportunity to talk to a nurse when needed. *NSW Bureau of Health Information (2016) Adult Admitted Patient Survey 2014 – Hospital care for Aboriginal People. NBMLHD Profile.* *NSW Bureau of Health Information (2016) Patient Perspectives: Hospital care for Aboriginal People.*

Outcomes of the health needs analysis – Substance Use (Aboriginal people)		
2.23	Community perceptions of health needs concerning substance use (Alcohol and Other Drugs)	Aboriginal consultants were engaged to conduct community forums in each of the LGAs as follow up from the Sharing and Learning Circles conducted during 2015 and to focus more specifically on Alcohol and Other Drugs, as well as Mental Health issues. Both these topics were identified as high priorities during the 2015 consultations. Forums were held in Blue Mountains, Penrith, Hawkesbury and Lithgow LGAs during September and October 2016. Analysis and reporting is in drafting process at the time of writing. The strongest themes raised by Aboriginal people attending these forums were constellated around: - The governance, accountability and congoing communication between the local Aboriginal Communities and services - Lack of access to appropriate services - Coordination of services. All concerns raised were underpinned by a lack of understanding from the services about Aboriginal People and the complex issues Aboriginal people are dealing with. The experience of some Aboriginal people is that access to AOD services may be due to a mandated requirement through child protection and justice services. In addition to long standing Aboriginal community mistrust of health services providers, because of personal or family and community experience, Aboriginal people in the NBM region **may regard providers of AOD services with even greater mistrust and fear**, and consequently may **avoid seeking assistance for emerging or long standing dependence on substances.** In response to both these issues local service providers who were involved in the consultations strongly identified the need for more Aboriginal people to be trained to

Outcomes of the health needs analysis – Substance Use (Aboriginal people)		
		facilitate and support access to AOD treatment on behalf of others because for many Aboriginal people self-referral is not considered. Consultation with local Aboriginal community controlled AOD service providers during 2016 indicates that due to a range factors including longstanding substance dependence, polydrug use, intergenerational and lived trauma, Aboriginal people often present for AOD treatment when they are in crisis. At these times, Aboriginal people present with multiple problems such as drug induced psychosis, acute physical illness and justice orders. Moreover, the complexity of these problems often means that a single treatment provider is unable to provide the support and treatment that clients require. Consultations with ACCHOs and the recently established Joint NBMLHD and NBMPHN Aboriginal Advisory Committee have indicated that these complex Aboriginal clients are experiencing an unsatisfactory and circular journey among multiple service providers, as well as poor outcomes. A constant theme and important message to health providers was that consultation processes aligned with funding or organizational agendas are irregular and may not effectively support Aboriginal people to provide needed feedback to commissioning agents or service providers. Communities consistently pointed to the need to develop better mechanisms to engage with local Aboriginal Communities in a more holistic way and more regularly. There is a need to engage with Aboriginal people in a way that values their lives as whole and listens to their perspectives on the relationship between factors in their lives and the complexities of dealing with their issues. Recommendations concerning improving future engagement of Aboriginal communities include: - Better alignment of Community and Service expectations to ensure appropriate communication and accountability - Alternative, complimentary programs that build on cultural strengths to engage people in developing positive coping strategies; - Provision of services to be person centered to find appropriate solutions;

Outcomes of the health needs analysis – Substance Use (Aboriginal people)		
		- Develop partnerships and pool resources with other government sectors/agencies e.g. Police, education, housing, sport and recreation, environment; CentreLink; to help develop appropriate solutions - Solutions focused approach i.e. act at the causes of the issues rather than the symptoms - Update communication mediums to integrate social networking - Investigate the use of Cultural Mentors to help develop an additional layer of support for Aboriginal People; - Intergenerational trauma needs to be recognised and addressed through innovative, locally developed and coordinated programs; - Assistance needed to strengthen Aboriginal Community and family structures and protocols - Explicit acknowledgement of the prevalence of systemic racism in health services and find ways to eradicate it – this will help develop trust with the Aboriginal Community - Find ways to develop and communicate a long term commitment to improving Aboriginal health outcomes - Services need to better cater for the fact that community needs may fall outside regular business hours - Integrate services better to hold the client at the centre of service provision i.e. different services need to help clients to navigate the system to get the best care - Increase the number preventative services available to address the underlying issues/considerations before people reach crisis - Ensure that services are free from judgment and trustworthy - Increase cultural knowledge/competency of service staff to reduce inappropriate service/care - Increase the numbers of Aboriginal workers in these services to reduce high burn out rates - Properly recognise the role of culture, family and community in healing.

Outcomes of the health needs analysis – Substance Use (Aboriginal people)		
		Shared Path Aboriginal and Torres Strait Islander Corp. Draft Report: Community Forums. NBMPHN, November 2016

Section 3 – Outcomes of the service needs analysis

DRUG AND ALCOHOL

Outcomes of the service needs analysis - AOD general population		
Identified Need	Key Issue	Description of Evidence
3.1 AOD treatment	Minimal options for local access to AOD treatment. Note that the following is a preliminary mapping of AOD services. Additional information such as the number of places available and any costs to clients will be added when service mapping is finalised and with the advice of the proposed AOD Regional Advisory Committee. Known additions will be services primarily aimed at providing mental health that also provides some AOD support with counselling.	It is acknowledged that certain people wish to access AOD treatment services outside their local area. This view has been stated by NADA, as well as DoH. NBMPHN preliminary investigation and consultations to date have not supported this position. By and large NBM community consultations have indicated a strong preference for the provision of these services locally, particularly where families are involved. For example, services for youth, men and women with children at home. Service mapping undertaken below has been limited to local and other metropolitan services in response to these preliminary findings. In addition services available only to local residents in other metropolitan areas have been excluded. They are: - Corella Lodge, Fairfield (Detoxification) - Langton Centre, Surry Hills - St George Drug and Alcohol Service, Kogarah *NADA, A planning tool for NGO alcohol and other drugs treatment services, March 2016.* *Department of Health, Guidance for Primary Health Networks, April 2016.*
3.2 Detoxification services	**NBM local detoxification services:**	**NBM local detoxification services:**

Outcomes of the service needs analysis - AOD general population		
	One local public detoxification service is available to residents of NBM region. This is located within the Penrith LGA. Travel time to this service is at least 2.5 hours one way for residents of Lithgow LGA and 0.5 to 1-5 hours for residents of Hawkesbury and Blue Mountains LGAs. One local private detoxification is available to residents of NBM region. This is located within the Hawkesbury LGA with travel time ranging from 2.5 hours to 0.5 hours, one way. **Other metropolitan locations**: A range of metropolitan services are available that would require considerable train or road travel. A number of these services are private hospitals requiring private hospital health insurance coverage. Lengthy travel time is a barrier to ambulatory detoxification and is also likely to be barrier to participants with family who need to stay in touch during an inpatient program. **Services self-indicated culturally secure for Aboriginal people**: Two services in other metropolitan locations indicate willingness to support culturally secure detoxification services. These are located in Darlinghurst and Surry Hills.	*NBM Drug and Alcohol Service, Penrith* Men, women and youth. Inpatient and outpatient detoxification. Supports drug use in pregnancy and opioid substitution. *St John of God, Richmond (Private Hospital)* Men and women. Detoxification for all drugs. Provides medicated detoxification, group and individual counselling, aftercare program. 3 week in-patient rehabilitation. Psychiatrist's referral with assessment report preferred. GPs may also refer. **Other metropolitan locations**: *Herbert Street Clinic, St Leonards*. Men and women. Medically supervised detoxification. Methadone detoxification under 40 mg only. Provides adult detoxification, group therapy, assessment and counselling. Abstinence philosophy (NA/AA) *Gorman House, Darlinghurst.* Men and women. Non-medicated detoxification in a 3-5 day program. Does not accept methadone, benzodiazepines, or cannabis. 20 bed unit with 17 female and 3 male beds. *Jarrah House, Malabar.* Women with or without children. Detoxification, residential rehabilitation, case management, non-residential activities and family support. *Northside Clinic, Greenwich (Private Hospital)*

Outcomes of the service needs analysis - AOD general population		
		Detoxification and rehabilitation program for all drugs. 3 week in-patient program. Open-ended two days per week outpatient program and relapse prevention as 10 week program. Abstinence philosophy (NA/AA). GP referral required. *Northside West Clinic, Wentworthville (Private Hospital)* 3 week residential detoxification and rehabilitation program. 40 beds. Provides outpatient program with relapse prevention. GP referral required. May have abstinence philosophy (NA/AA) *Odyssey House, Campbelltown* Men, women and families. Capable for people with comorbid mental health and AOD problems. Provides detoxification, residential rehabilitation, therapeutic community, case management, non-residential activities, family support, living skills programs. *Program for Adolescent Life Management (PALM), Randwick (Ted Noffs Foundation)* For youth. Provides detoxification, residential rehabilitation, therapeutic community, case management, nonresidential activities including living skills programs. *SA William Booth House (Salvation Army), Surry Hills* Men, women and **Indigenous Australians**. Provides detoxification for injecting drug users, homeless people, people with comorbid mental health and AOD problems, and CALD communities. Detoxification service includes residential rehabilitation, therapeutic community and family support. *St John of God, Burwood (Private Hospital)*

Outcomes of the service needs analysis - AOD general population		
		Men and women. Detoxification for all drugs. Provides medicated detoxification, group and individual counselling, aftercare program. 3 week in-patient rehabilitation. Psychiatrist's referral with assessment report preferred. GPs may also refer. *St Vincent's Hospital AOD Service, Darlinghurst* Men, women and **Indigenous Australians**. Detoxification service for injecting drug users, homeless people and people with comorbid mental health and AOD problems. Services include pharmacotherapies, detoxification, case management and non-residential activities. *South Pacific Private (Hospital), Curl Curl* Inpatient detoxification for unspecified length of time. Outpatient day program post discharge. *The Sydney Clinic, Bronte* Men, women, and dual diagnosis capable. Requires top medical cover. Inpatient medicated detoxification 15-21 days followed by day program. Referral from GP required. *Wesley Private Hospital, Ashfield and Kogarah* Private psychiatric hospital providing detoxification as inpatient and outpatient programs. Dual diagnosis capable. GP referral required. *Family and Community Services, NSW/ACT Drug and Alcohol Service Directory, January 2016*.
3.3 Outpatient detoxification-counselling and non-residential rehabilitation services	**NBM local services:** One NGO non-residential rehabilitation service is located within the region at Katoomba. This is a relatively new and small service that supports women only. Indications are that this is a low intensity service.	**NBM local services:** *Dianella Cottage, Katoomba* For women only. Payment by donation if affordable. This is a non-residential day program with group work, 1:1 work, drop in facilities, access to SMART recovery meetings.

Outcomes of the service needs analysis - AOD general population		
	The WHO's West service is provided at Penrith and supports both men and women including those with high needs. The main regional outpatient service is provided by NBMLHD at Penrith and Katoomba locations. **Other metropolitan services**: A range of metropolitan services are available that would require considerable train or road travel. A number of these services are private hospitals requiring private hospital health insurance coverage. Lengthy travel time is a barrier to ambulatory detoxification and is also likely to be barrier to participants with family who need to stay in touch during an inpatient program. **Services self-indicated culturally secure for Aboriginal people**:	*Woodlands Clinic: Blue Mountains Hospital* Comprehensive medicated assisted treatment program for opioid dependence as an outpatient service. *WHOs West, Penrith* Men and women. WHO's West offers assessment, referral services and residential supported care for individuals from the NBM districts. There are 6 transitional housing beds located in Penrith and 7 residential care beds located at the Roselle Campus. *Pathways Penrith (NBMAOD)* Men, women and youth. Inpatient and outpatient detoxification, drug use in pregnancy, and opioid substitution. *State Community Health Centres in NBM region:* - Youth drug and alcohol counselling service (YDAS) - Adult drug and alcohol counselling service - Magistrates early referral into treatment (MERIT) team - Adult drug court (ADC) team - Quit for new life counselling (Q4NL – Closing the Gap in Aboriginal health strategy) - Drug and Alcohol Psychology Team. These services are located at the Nepean Campus (Opioid Treatment Program and Outreach), Penrith Community Health Centre, St Mary's Community Health Centre, Cranebrook Community Health Centre and Katoomba Community Health Centre. **Other metropolitan services**:

Outcomes of the service needs analysis - AOD general population		
	There are no self-indicated services identified in the region or metropolitan areas that provide specialized AOD services for Aboriginal people, according to reports accessed. However just outside the regional boundaries, Marrin Weejali, an ACCHO is located on the eastern border near to Penrith.	*Marrin Weejali Aboriginal Corporation, Blackett* As part of **Aboriginal specific Social and Emotional Wellbeing Services**, this program provides S.M.A.R.T Recovery Program (stages 1 to 3). This is a self-help group that assists clients to recover from addictive behaviours. It teaches practical skills to help deal with problems and gaining a more balanced life style. The program involves, motivation, coping skills and problem solving. *Centre for Addiction Medicine, North Parramatta* Men and women. Provides drug and alcohol outpatient clinic, pharmacotherapy and drug and alcohol counselling. *Continuing Adolescent Life Management (CALM), Randwick (Ted Noffs Foundation)* For young people between 13-18 years of age. Will accept comorbid clients on a case by case basis. Provides community-based therapeutic services including individual and family counselling, life skills development and educational, vocational programs and a medicated 2 week detoxification program. *Maryfields Day Recovery Centre, Campbelltown (St. Vincent de Paul Society)* Men, women and families. This is a 10 week program with case management, non-residential activities, family support, living skills programs. *Phoenix Treatment Facility (Kedesh Services), Balgowlah* Men and women. No detoxification service. Cognitive behaviour therapy (CBT), acceptance and commitment therapy (ACT), psychodynamic therapies, attachment theory, family systems theory, Gestalt therapy, solution focused therapy and positive psychology.

Outcomes of the service needs analysis - AOD general population		
		Royal Prince Alfred Drug Health Service, Camperdown Men and women. Outpatient medical clinics, outpatient counselling, opiod treatment program, counselling, perinatal and family drug health services. *Centre for Addiction Medicine, North Parramatta* Men and women. Drug and alcohol outpatient clinic. Pharmacotherapy and drug and alcohol counselling. *St Vincent's Stimulant Treatment Program & Telephone Line, Darlinghurst* STP works with stimulant users who wish to develop safer ways of using and /or attain or maintain abstinence. Harm minimization is the overarching framework of this service. The telephone line is a NSW state-wide telephone service providing education, information, referral, crisis counselling and support specifically for stimulant use such as speed, ice ecstasy and cocaine. *Family and Community Services, NSW/ACT Drug and Alcohol Service Directory, January 2016*.
3.4 Residential rehabilitation & therapeutic communities	**NBM Local Services:** The identified state funded residential rehabilitation beds for the NBM region are not located in the region. They are located in a specialist facility approximately 1 hour drive from eastern border of the region and Penrith. One NGO provides residential rehabilitation in the NBM region and another at Werrington borders on the NBM region to the east. Both facilities cater only for men. One	**NBM Local Services:** *One80TC (formerly teen challenge), Richmond* Males only 18-35 years. Long term (12 month) residential rehabilitation. Detoxification needed prior to entering program. Living skills programs, life skills management. May take co-morbid clients on case by case basis. *WHOs West, Penrith* Men and women. WHO's West offers assessment, referral services and residential supported care for individuals from the NBM districts. There

	provides only a 12 month program aimed at young men aimed at delivering life skills as part of rehabilitation. This is a highly selective program. The other provider a 9-12 month program for adult men are risk of or homeless. There is long term residential rehabilitation beds open to men based on selective criteria and no residential beds for women at the time of reporting. However 180TC is currently developing a small women's residential facility in Kurmond to be opened in the near future. **Other Metropolitan Services:** Similar to other AOD treatment categories, a range of metropolitan residential rehabilitation services are available that would require considerable train or road travel. A number of these services are private hospitals requiring private hospital health insurance coverage. Lengthy travel time is a barrier to participants with family who need to stay in touch during a residential program. **Services self-indicated culturally secure for Aboriginal people**: There are no reported self-indicated culturally secure residential rehabilitation beds for Aboriginal people in metropolitan Sydney or NBM region.	are 6 transitional housing beds located in Penrith and 7 residential care beds located at the Rozelle Campus. **Other Metropolitan Services:** *Adele House, Werrington* Men only who are homeless or at risk of being homeless. 9-12 month residential program. *Detour House, Glebe* Women only. Residential rehabilitation, non-residential activities, family support, living skills programs. *Foundation House, (Construction Industry Drug and Alcohol Foundation) Rozelle* Men and women. Residential rehabilitation, non-residential activities, living skills programs and workplace AOD. *Glebe House, Glebe* Men, CALD and people with comorbid mental health and AOD problems. Residential rehabilitation, case management, family support, living skills programs. *Gunyah, WHOs, Rozelle* Men only, Long term therapeutic residential community. Requirement for detoxification prior to admission. *Guthrie House, Enmore* Women, parents with children, homeless people and people with comorbid mental health and AOD problems. Provides pharmacotherapies, residential rehabilitation, family support, living skills programs.

Outcomes of the service needs analysis - AOD general population		
		Jarrah House, Malabar. Women with or without children. Detoxification, residential rehabilitation, case management, non-residential activities and family support. *Kathleen York House, Glebe* Women with or without children. Residential rehabilitation, case management, non-residential activities, family support. *New Beginnings WHOs, Rozelle* Women only. Long term residential rehabilitation program. *Odyssey House, Campbelltown* Men, women and families. Capable for people with comorbid mental health and AOD problems. Provides detoxification, residential rehabilitation, therapeutic community, case management, non-residential activities, family support, living skills programs. *Program for Adolescent Life Management (PALM), Randwick (Ted Noffs Foundation)* For youth. Provides detoxification, residential rehabilitation, therapeutic community, case management, nonresidential activities including living skills programs. *RTOD, WHOs, Rozelle* Men and women. Residential rehabilitation to allow stabilization on opioid substitution program. No minimum dose. Must be detoxed from alcohol and or benzodiazepines prior to admission. *SA William Booth House (Salvation Army), Surry Hills*

Outcomes of the service needs analysis - AOD general population		
		Men, women and **Indigenous Australians**. Provides detoxification for injecting drug users, homeless people, people with comorbid mental health and AOD problems, and CALD communities. Detoxification service includes residential rehabilitation, therapeutic community and family support. *Wayback Committee, Harris Park* Men and women. People with comorbid mental health and AOD programs. People can apply from jail however cannot come directly from jail. May be able to accept some detoxification cases on a case by case basis. Provides pharmacotherapies, residential rehabilitation, case management, living skills programs. *Family and Community Services, NSW/ACT Drug and Alcohol Service Directory, January 2016*.
3.5 Other specialist services	Family and child support is provided by two NGOs in the region in the Blue Mountains and Penrith LGAs. Bridging the Divide also aims to improve service integration between treatment providers and community service providers. Two youth specialist services and one specialist women's service operate in western Sydney and regions bordering on NBM region. Travel time for NBM residents would range from 1 to 4 hours, one way. One specialist youth service supports non-specialist counselling for **Aboriginal people** in the adjoining region of Western Sydney.	*Family Drug Support, Leura (Bridging the Divide)* Primarily volunteer programs to offer support to families impacted by substance use. Bridging the Divide builds partnerships with treatment services and other relevant communities and organisations to improve client engagement with services and increase effectiveness of treatment. *Bernado's Penrith, Cranebrook* Temporary accommodation, crisis intake. Child and family support. *Follow On Youth Recovery Support Team, FYRST, Fairfield and Parramatta* Youth between 12-24 years. Outpatient drug and alcohol counselling and education in addition to a range of health service, housing and basic needs support. *High Street Youth Health Service, Harris Park*

Outcomes of the service needs analysis - AOD general population		
		Outpatient drug and alcohol counselling and education, in addition to a range of health service, housing and basic needs support. *Mums and Kids Matter, Wesley Mission, Liverpool* Mothers with mental illness & young children (0-5). Will take women with comorbid drug and alcohol problems on a case by case basis. Provides long-term support, mentoring, specialist assistance tailored to the individual needs of mothers and children. Residential facility which can accommodate up to 8 mothers and children. Plus in-home community packages for up to 15 mothers and children (one child less than 5 years). *Street University Ted Noffs – Mount Druitt* Provides counselling 5 days a week including specialist Indigenous counselling and workshops. *Family and Community Services, NSW/ACT Drug and Alcohol Service Directory, January 2016*. *NADA, Member Services reports provided, 2016*
3.6 Poor access to rehabilitation services for women	Improved access to services for women and particularly women with children was identified as the highest priority by a large proportion of respondents that formed part of Project Skylight (2010). Subsequent to that report the funds from the liquidation of Westmount Rehabilitation centre at Leura were directed to the establishment and operation of Dianela Cottage, Katoomba where day care is provided in group and one-on-one counselling. These were not recurrent funds.	Respondents described the difficulties encountered by women as: - Women with children often feared that by entering treatment they would disclose their substance habit and risk have their children taken into protective care. - A general lack of child care provided by treatment services including group support such as AA and NA. - Areas of disadvantage in the Blue Mountains were regarded as North Katoomba, the Hazelbrook areas and the Lower Mountains. Respondents recommended the following interventions:

Outcomes of the service needs analysis - AOD general population		
		- Community based options for detoxification in safe environments for women with children - Intensive support, service co-ordination and case management for women with children, possibly using a mobile-outreach model - Coordinated support for pregnant substance users - Child care for recovery groups - Outreach to Blue Mountains women's services - Capacity development of community based workers. *Project Skylight - Blue Mountains Drug and Alcohol Recovery Services Inc., Report 2: Alcohol and other drugs in the Blue Mountains, 2010.*
3.6.1 Care Coordination	Inadequate service models for early intervention and effective support and treatment	Preliminary consultation with service providers indicate that: - Drug and alcohol presentations represent approximately 20% of all presentations to ED - There are insufficient numbers of Aboriginal health workers in drug and alcohol services - It is likely that one in four inpatients could meet criteria for D&A treatment however most of these patients are not aware that they have a problem - Excluding detoxification - drug and alcohol related hospital separations are one of the top 5 medical DRGs with an average of 80 separations per month - There are difficulties obtaining D&A consultations for patients presenting to ED and other hospital services - There are currently no mechanism or links for shared care or advice between the regional drug and alcohol service and general practice *NBMPHN Preliminary Stakeholder Consultations for Drug and Alcohol, 2016*

Outcomes of the service needs analysis - AOD general population		
3.7 Poor access due to limited service hours and availability of counselling	Strong indications that access to early intervention, counselling and aftercare is fragmented and inadequately resourced.	Post-care or aftercare is recognised as important to prevent relapse following treatment. NADA (2013) reported that there is currently no systematic approach or dedicated funding to AOD services for the provision of post care programs across the sector. Consultation and review of Drug and Alcohol services indicate: • Limited after hour services particularly for youth (12-20 yrs) • Lack of addiction medicine specialists in community setting • Low staffing levels and long wait lists • Very limited outreach clinics for youth (12-20yrs) • Limited GP experience in dealing with D&A clients • Poorer access for Aboriginal clients drug and alcohol services is: - Poor due to hours of service operation - Difficult for youth and Aboriginal clients - Poor due to inadequate staffing levels. *NBMLHD Health Services Plan 2012/2022* *Staff consultation, NBMLHD*
3.8 Coordination of Care	D&A services operate independently of mental health services, have limited focus on clients holistic well-being and the 'whole of family' approach has not been adopted.	Consultation and review of D&A services indicate: • Prevalence of dual diagnoses with mental health and D&A clients • Absence of service collocation with mental health services • Poor focus on holistic care / physical well being • Lack of 'whole of family' approach in treatment plan and therapy Further research is required to explore models of care that incorporate holistic management.

Outcomes of the service needs analysis - AOD general population		
		NBMLHD Epidemiological profile 2014 *NBMLHD Health Services Plan 2012/2022*
3.9 Smoking Cessation Programs	Indications that Drug and Alcohol services need to broaden and implement more smoking cessation programs	Consultation and review of D&A services indicate: • Lack of smoking cessation clinicians in Child and Family Nursing teams • Lack of smoking cessation programs within Aboriginal maternal health services. *Staff consultation, NBMLHD*
3.10 Child and Youth D&A Services	Lack of appropriate detoxification service for young people for drug or alcohol withdrawal.	Stakeholders have identified the need for specific detoxification services to support the withdrawal of young people from long term drug or alcohol substance use. Further research is required to examine existing detoxification treatment options for young people in the NBM region. Stakeholder have raised the following concerns: • Lack of provision for young people within the detox facility at Nepean Drug and Alcohol Service, with regards to being in the same environment as adults. • Lack of free or cheap detox/rehab facilities. *Stakeholder Consultation, NGO 8/3/16* *NBMPHN GP and AHP Consultations March 2016*
3.11 Community Wide Communication For Youth: D&A	Enhanced and targeted communication methods are required to engage and inform young people about the use of drugs and alcohol.	Stakeholders have raised the following concerns regarding community wide engagement and education of young people: • Lack of D&A services within the community to help engage and educate young people.

Outcomes of the service needs analysis - AOD general population		
		• Lack of education for young people in relation to the effects of Drug and Alcohol. • Lack of community education and understanding of ICE. *NBMPHN GP and AHP Consultations March 2016* *Stakeholder Consultation, NGO 8/3/16*
3.12 Workforce Capacity Including Skills And Training	There is a general view that workforce capacity for drug and alcohol services in the region could be substantially improved with training and skills development.	Further research is needed to examine the potential sources of the issues raised by stakeholders to develop appropriate options. The concerns raised by stakeholders were: • Increase GPs knowledge of available clinical and non-clinical services and their referral pathways. • Increase GP capacity to identify early if consumer has substance use problems • Need for trauma education for health professionals. • Lack of GP Education dual diagnosis drug and alcohol & severe mental illness. • Insufficient dual diagnosis support and supervision for private therapist. • Lack of support workers who are available after hours and on weekends. *NBMPHN Mental Health Stakeholder Forum 23/2/16* *NBMPHN GP and AHP Consultations March 2016*

ALCOHOL AND OTHER DRUGS: ABORIGINAL PEOPLE

Outcomes of the service needs analysis: AOD services for Aboriginal people		
Identified Need	Key Issue	Description of Evidence
3.13 Indigenous corporations – community services	The NBM region has a number of active Aboriginal corporations, especially in the Blue Mountains region to support Aboriginal community engagement with AOD regional planning for Aboriginal people.	**NBM region**: *Cawarra Women's Refuge Aboriginal Corporation, Kingswood* Provides accommodation and counselling support. *Indigenous Disability Advocacy Services, Penrith* Disability services. *Merana Aboriginal Community Association for the Hawkesbury, Richmond* Community development, support, programs and resources. *Blue Mountains Aboriginal Cultural and Resource Centre, Katoomba* Cultural services including advocacy and resources. *Gundungurra Aboriginal Heritage Association Inc., Lawson* Cultural services, awareness programs and recording sacred sites. *Gundungurra Tribal Council Aboriginal Corporation, Katoomba* Cutlural services, representing Gungungurra people. *Katoomba Indigenous Outreach, Katoomba* Drop in information, advisory and advocacy service. *Muru Mittigar Aboriginal Education and Resource Centre, Castlereagh* Employment services supporting Aboriginal people and cultural awareness. **Adjoining regions:**

Outcomes of the service needs analysis: AOD services for Aboriginal people		
		Gilgai Aboriginal Centre Inc., Mount Druitt Community service provider for aged and disabled. *Footprints in Time, Blackett* Longitudinal study of Indigenous children. Link Up Counselling Services Counselling and support especially for Stolen Generation. *Darug Tribal Aboriginal Corporation, Blacktown* Cultural Services, resources. *Aboriginal Medical Service, Western Sydney* Medical service, currently managed by the WSPHN. Has provided specialist AOD in the past and may do so in the future. *Aboriginal Employment Strategy, Blacktown* Indigenous managed recruitment organisation. *Step Up Indigenous Employment Solutions. Mt Druitt* Providing long term employment solutions to Aboriginal people. *Aboriginal Legal Service NSW, Parramatta* Legal representation. *CatholicCare Social Services, Parramatta Diocese. Mapping Aboriginal Services in the Diocese of Parramatta. 2012*
3.14 Mainstream (NGO) programs with Aboriginal workers	The NBM region has access to a number of NGOs with Aboriginal liaison and community workers to support	**NBM Region:** *Blue Mountains Youth Accommodation and Support Service Inc, Springwood*

Outcomes of the service needs analysis: AOD services for Aboriginal people		
	Aboriginal community engagement with AOD regional planning for Aboriginal people.	Assisting homeless youth. *Nepean Community and Neighbourhood Services, South Penrith* Community development. *Miimali Aboriginal Community Association, St Mary's* Supporting Aboriginal youth 12-18 years. **Adjoining regions:** *Eddy's Out West, Blacktown* Transitional accommodation for youth. *Jessie Street Domestic Violence Service, Doonside* Supporting Aboriginal women with emergency accommodation. *Yawarra Community and child care centre, Bidwill* Long day care for children. *Learning Ground, Bidwill* Capacity building in the community. *Mount Druitt – The Shed, Emerton* A safe place for men and social inclusion. *Salvation Army (New Careers for Aboriginal People Program), Mt Druitt* Increase employment participation for Aboriginal people. *Aboriginal Legal Access Program, Windsor* Legal Services. *Marist Post Release Support Program, Blacktown*

Outcomes of the service needs analysis: AOD services for Aboriginal people		
		Support transitioning through custody. *Family and Community Services, NSW/ACT Drug and Alcohol Service Directory, January 2016*.
3.15 Provision of services for Aboriginal people	Inadequate service models for early intervention and effective support and treatment	Preliminary consultation with service providers indicate that: - Drug and alcohol presentations represent approximately 20% of all presentations to ED - There are insufficient numbers of Aboriginal health workers in drug and alcohol services - It is likely that one in four inpatients could meet criteria for D&A treatment however most of these patients are not aware that they have a problem - Excluding detoxification - drug and alcohol related hospital separations are one of the top 5 medical DRGs with an average of 80 separations per month - There are difficulties obtaining D&A consultations for patients presenting to ED and other hospital services - There are currently no mechanism or links for shared care or advice between the regional drug and alcohol service and general practice. *NBMLHD AOD Strategic Planning Forum, February 2016*
3.16 Provision of services for Aboriginal people	Inadequate access to culturally secure detoxification and rehabilitation and aftercare services in the region.	Project Startlight (2010) reported service provider recommendations for improved access to services for Aboriginal people in the region. Concerns were expressed regarding lack of aftercare to support people who were living in an environment with other substance users and experienced peer pressure to resume substance use following rehabilitation. Service providers recommended the following interventions targeting Aboriginal people involved in substance use:

Outcomes of the service needs analysis: AOD services for Aboriginal people		
		- Training for service providers to improve awareness of the link between substance use and Stolen Generation issues - Strategies to reach young people who may be at the crossroads of substance use and substance addiction - Soft entry options for access to AOD treatment when AOD issues arise in the context of other service provision - Post treatment support for Aboriginal people who have been through residential rehabilitation programs - A culturally secure drop in centre with male and female Aboriginal workers. *Project Skylight - Blue Mountains Drug and Alcohol Recovery Services Inc., Report 2: Alcohol and other drugs in the Blue Mountains, 2010.*
3.17 Capacity of Services For Aboriginal People	Inadequate capacity of primary health services to respond to Aboriginal health needs.	The Sharing and Learning Circles conducted in each LGA identified the importance of building service capacity to meet broad range needs for Aboriginal health service provision. **Inadequate knowledge of health services**: was identified as an issue by each community group. The primary concern is one of knowledge and lack of access to relevant information to support equitable and necessary access to health services. This prevents Aboriginal people from attempting to access a range of services. Lack of knowledge of entitlements was also identified as part of this issue. When unique services and supports are provided to support identified issues, Aboriginal people are often not aware of these opportunities due to social and cultural isolation. **Lack of trust** in mainstream service providers was identified as a barrier to access by each of the community groups. Examples given were CTG benefits not provided by certain pharmacies.

Outcomes of the service needs analysis: AOD services for Aboriginal people		
		Cultural safety was identified by all community groups either directly or indirectly. There is limited and potentially no access to Aboriginal medical service providers in the region due to the uncertain future of the Mount Druitt and Penrith services. A culturally safe environment recognises and respects traditional values, norms and preferences, and supports the dignity and cultural identity of each individual. **Engagement with services by Aboriginal people**: Each community group indicated that there are no clear mechanisms for Aboriginal people to become involved in the governance of health services in the NBM region. The broad issues raised were the need for information, forums, engagement with identified providers to facilitate access and linkages to other services. There appeared to be no specific mechanisms in place to support the engagement of Aboriginal people in the decision making and development of service provision for their communities. *NBM Sharing and Learning Circles, Blue Mountains LGA, Hawkesbury LGA, Penrith LGA, Lithgow LGA, 2015*
3.18 Capacity of Services For Aboriginal People	Additional AOD and related services required needed to meet identified needs.	**Drug and Alcohol:** Inadequate supply of culturally safe drug and alcohol services has been identified for the region. Additional services are needed especially to support Aboriginal people with mental health problems, and for culturally safe detoxification services or dedicated facility. **One stop shop:** A central point where Aboriginal people can access a broad range of information, coordination and support was absent. This is not necessarily a location for service provision, but rather a place where Aboriginal people can feel safe to participate and discuss their needs in order to understand service provision options and facilitate access. **Mental Health:** There is a need for more appropriate follow up and support for dual diagnosis for substance abuse and mental health issues.

Outcomes of the service needs analysis: AOD services for Aboriginal people		
		The importance of mentoring was identified as part of a culturally safe response to mental health issues. *NBM Aboriginal Sharing and Learning Circles, Blue Mountains LGA, Hawkesbury LGA, Penrith LGA, Lithgow LGA, 2015*