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HUNTER NEW ENGLAND AND CENTRAL COAST

An Australian Government Initiative

DRUG AND ALCOHOL NEEDS ASSESSMENT: 2017 UPDATE

Hunter New England and Central Coast Primary Health Network

Australian Government
Department of Health

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An Australian Government Initiative

Primary Health Network

Needs Assessment Reporting Template

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 **30 March 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

Hunter New England & Central Coast

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

This section provides PHNs with the opportunity to provide brief narratives on the process and key issues relating to the Needs Assessment.

Needs Assessment process and issues

– in this section the PHN can provide a summary of the process undertaken; expand on any issues that may not be fully captured in the reporting tables; and identify areas where further developmental work may be required (expand this field as necessary)

This Drug and Alcohol Needs Assessment update for Hunter New England and Central Coast (HNECC) Primary Health Network (PHN), provides a solid foundation on which to make evidence and resource based decisions.

A comprehensive review of updated available data on problem Drug and Alcohol usage prevalence was undertaken. This included the review of: the Australian Institute of Health and Welfare, National Drug Strategy Household Survey results; Australian Bureau of Statistics (ABS); Public Health Information Development Unit (PHIDU); National Survey of Mental Health and Wellbeing results; the ABS Australian Aboriginal and Torres Strait Islander Health Survey results; and Centre for Epidemiology and Evidence NSW Health, Methamphetamine-related Hospitalisations data. In parallel with this work, stakeholder engagement was undertaken and captured across the organisation.

Relevant information from the Mental Health and Suicide Needs Assessment report 2017 was used for this drug and alcohol needs assessment update, which identified quantitative drug and alcohol data from the publicly available sources listed above. The report identified relevant qualitative drug and alcohol data through key stakeholder interviews, an online forum and surveys. Across all LGAs in the HNECC PHN region, interviews were conducted with key stakeholders including: consumers, carers and community members; service providers from mental health and other community services; and GPs and other medical specialists.

Relevant stakeholder information was gathered from the HNECC Regional Drug & Alcohol Networks Service Mapping Survey Report, 2017 which explored Drug and Alcohol service issues in the HNECC region. There was a total of 22 respondents to the survey. The key stakeholders involved in this survey included specialist non-government treatment providers; HNE and CC Local Health District (LHD) Drug and Alcohol services; Aboriginal Community Controlled Health Organisations; and NADA Non-Government Treatment Provider Members.

This Drug and Alcohol Needs Assessment update provides a comprehensive, defensible and accurate picture of the Drug and Alcohol treatment service needs across our region and aids in the development of an Activity Work Plan to address these priorities. For the purpose of clarity, new information that has been updated has been displayed in red font colour.

Additional Data Needs and Gaps (approximately 400 words)

– in this section the PHN can outline any issues experienced in obtaining and using data for the needs assessment. In particular, the PHN can outline any gaps in the data available on the PHN website, and identify any additional data required. The PHN may also provide comment on data accessibility on the PHN website, including the secure access areas. (Expand field as necessary).

Data regarding services and treatments for people with drug and/or alcohol-related issues were reviewed from a range of sources. Information and data at local or PHN levels was not available in the majority of data reviewed, with the exception of ATAPS MDS data. State-wide numbers of clients and episodes of care by in-hospital, residential settings, community health and some NGO settings was reviewed, but without small area data it is difficult to make conclusions about met need in the HNECC PHN region. Limited information was available regarding alcohol-specific treatments generally. Opioid treatment programs are better reported (e.g. the submission of the NSW NMDS to NADA by all government and non-government drug and alcohol agencies receiving NSW Ministry of Health funding to provide specialised drug and alcohol services) but information at local or small areas was not available at the time of this review.

There are a number of key challenges in developing a comprehensive picture of the Drug and Alcohol treatment needs across the HNECC PHN region. These relate to the nature of the issues being dealt with and their potential stigma on those seeking assistance; the movement of individuals across regions and borders to seek treatment; the availability of particular targeted services in specific areas; the organisational design of providers who do not necessarily conform to defined regions; and the confounding issues of co-morbidity, particular mental illness. These factors affect the demand and supply of Drug and Alcohol treatment services and result in a fluid situation at any given point in time.

A number of the key data sources are only available on a larger or different regional, jurisdictional or national basis. As such, estimates of the burden of disease have been used when extrapolating these data for use at a PHN level. This is likely to lead to some distortion of the demand levels, though given the apparent chronic undersupply of services to meet that demand, these variances are unlikely to be material at this stage. There is also a need for data to align with the new LGA boundaries.

At this stage there is very little, if any data, available through the PHN website that is relevant to Drug and Alcohol use, it would be our expectation that this resource be expanded substantially in the near future to facilitate a comprehensive continuing needs assessment process for the HNECC PHN region. In regards to the PHN website in general, as the site (including the secure data section) continues to grow, accessibility could be greatly improved by:

- Clear labelling of links to data files, including content and publication date
- Publication of data dictionaries and any metadata regarding specific datasets
- Consistent format and layout of spreadsheet (csv, excel) files
- Publication of update schedules for each data set
- Access to a subscription service which alerts subscribers to new and updated data
- A separate subscription service for users with secure area access

Whilst we reviewed the range of resources suggested in the tool kit to support the data needs of this undertaking, we felt that these were inadequate in providing an accurate picture of need relating to Drug and Alcohol use across the HNECC PHN region. We have included specific requirements below:

- We require data to be provided at the PHN level as a minimum and would prefer data be provided at LHD and SA3 levels.
- Access to up to date data is crucial to the success of this activity, particularly given the anecdotal reports of the increasing misuse of methamphetamine use, especially in rural areas, it is challenging to accurately gauge the scale and impact of this issue without the solid evidence base of current data.
- Due to the tendency for clients to access a service outside of their local community, any treatment data made available would be enhanced through the provision of residential postcodes or SA3's, this would provide valuable information regarding client flows.
- Access to comprehensive data from the NADAbase MDS on a regular and ongoing basis, preferably quarterly, is also required.

Additional comments or feedback (approximately 500 words)

– in this section the PHN can provide any other comments or feedback on the needs assessment process, including any suggestions that may improve the needs assessment process, outputs, or outcomes in future (expand field as necessary).

The development of a comprehensive picture of drug and alcohol treatment service needs across the HNECC PHN region is a significant undertaking. The nature of the sector, diverse organisational types that provide the services and their subsequent treatment focus, differing treatment funding models and historical practices result in a complex and somewhat dynamic environment. In depth understanding of these complexities can only come with time and sustained engagement with the sector. The original Drug and Alcohol Needs Assessment provided an excellent baseline for the development of this understanding, however the continual refining process, including this update, enhance its accuracy and durability, and ensure it remains relevant as the sector responds to community needs and potential new issues arise.

In addition to this, HNECC has established a specialist advisory group consisting of key stakeholders from the public health sector to assist in the development of strategy direction, networks to improve communication, information sharing and overall coordination of the PHNs activities.

Performance measures

HNECC is developing a Health Outcomes Framework to support the measurement and reporting of the health and wellbeing outcomes of HNECC activities. In alignment with the Quadruple Aim methodology adopted by HNECC, the Framework will guide efforts in delivering a primary health system that supports HNECC PHN residents to be as healthy as they can be, while enhancing patient experience and care outcomes, improving the experience of the clinician, and driving greater value for investments. To assist in identifying local indicators to measure the attainment of intended outcomes for each activity, we have altered table 3 to reflect the recommended process outlined in the 'PHN Performance Framework'. Under 'Possible Performance Measurement', we have included additional columns to capture the following:

• Availability of appropriate indictors from national datasets. Here suitable indicators from a range of datasets has been included:

- Australian Institute of Health and Welfare (AIHW) – My Healthy Communities reports
- Public Health Information Development unit
- Department of Health/ AIHW PHN data website
- AIHW METeOR – Health Sector National Minimum data sets
- PHN secure data website

•PHN identified outcome measures: e.g. Patient Reported Outcome Measure (PROMs); Patient Reported Experience Measures (PREMs); Clinical outcome measures; Provider experience measures.

• PHN identified process/output measures

The activities of HNECC occur in an environment where multiple programs and policies are simultaneously attempting to achieve improvement across the health system. With this in mind, we have made an attempt to indicate whether changes in a particular national indicator are anticipated to be a direct or indirect result of the contribution of HNECC and its providers. Attributing a change in national indicators directly to the activities of HNECC depends on a number of factors, including the characteristics of the activities pursued, the specification of the indicators and the local context. If an activity is targeting a sub-PHN region, and data to support the measure is available at sub-PHN geography, such as SA3, this has been mentioned.

These suggested possible performance measures have assisted HNECC to align with the Quadruple Aim methodology and relate our activities and associated indicators to the objectives of PHNs, national priority areas, and/or national headline indicators, and will:

- be further developed and refined with assistance from external evaluation experts, initially focussing on the development, collection and analysis of PREMS and PROMs and establishing targets;
- be reviewed by relevant HNECC program managers, who along with relevant stakeholders and service providers, will select the most appropriate local indicator(s) and targets for each activity they undertake that best demonstrate their effect on local priorities, which will be included in HNECC Activity Work Plans; and
- aid in the development of the HNECC PHN Outcomes Framework.

Section 2 – Outcomes of the health needs analysis

This section summarises the findings of the health needs analysis in the table below. For more information refer to Table 1 in '5. Summarising the Findings' in the Needs Assessment Guide on www.health.gov.au/PHN.

Additional rows may be added as required.

Table 1

Outcomes of the health needs analysis		
Identified need	Key Issue	Description of Evidence
Alcohol misuse	Alcohol misuse is an increasing concern for stakeholders across the HNECC PHN region. In Australia, excessive alcohol intake is a major risk factor for ill health and death. Binge drinking for example is linked to injury and road accidents, violence and chronic disease. Between 2012 and 2013, the rate of alcohol attributed deaths was higher in the HNECC PHN region (20.4 per 100,000) compared to the NSW average (16.1 per 100,000). Hospitalisations In 2014-15, in the HNECC PHN region, the rate of mental health overnight hospitalisations for drug and alcohol use hospitalisations was 267 per 100,000, similar to the 2013-14 rate (260 per 100,000) and substantially higher than the national rate (180 per 100,000). The bed day rate was 2,007 per 100,000 (Australia: 1,369 per 100,000). In 2014-15, at a local level, the rate of drug and alcohol use hospitalisations was higher than the Australian average in all SA3s, with the highest rates in Wyong (381 per 100,000 - almost twice the Australian average), Moree-Narrabri (339 per 100,000), Gosford (337 per 100,000) and Great Lakes (319 per 100,000), and the lowest rates in Tamworth-Gunnedah (183 per 100,000) and Maitland (190 per 100,000). The associated bed day rate ranged from 3,595 per 100,000 in Great Lakes to 981 per 100,000 in Armidale. Between 2014-15, within the HNECC PHN region, the rate of alcohol attributed hospitalisations were higher for males (724.0 per 100,000) compared to females (500.8 per 100,000).	*Australian Bureau of Statistics. National Survey of Mental Health and Wellbeing: Summary of results, 2007, Cat. No. 4326.0. Canberra: Australian Bureau of Statistics, 2008* *Alcohol attributable hospitalisations by sex, HNECC PHN, NSW 2001-02 to 2014-15; alcohol attributable deaths by PHN, NSW, 2012-13 (Centre of Epidemiology and Evidence NSW Health.* *Australian Institute of Health and Welfare. My Healthy Communities, 2017* *Australian Institute of Health and Welfare 2017. National Drug Strategy Household Survey 2016: detailed findings. Drug Statistics series no.31. Cat. No. PHE 214. Canberra: AIHW.* *National drug strategy household survey (NDSHS) 2016- key findings (AIHW, 2017).* *Consultation with HNECC Central Coast Clinical Council, 2016.* *AIHW (AODTS-NMDS, NOPSAD, NHMD-NMDS, Aboriginal and Torres Strait*

Outcomes of the health needs analysis		
	Alcohol Consumption In 2016, in Australia, there was a higher proportion of young people aged 12-17 years abstaining from alcohol (82%) compared to 2013 (72%). The average age at which young people (aged 14-24 years) start drinking has increased from 14.4 in 1998 to 16.1 in 2016. Between 2010 and 2016, young adults (18-24 years) have reduced their consumption of alcohol, with a lower proportion exceeding the lifetime risk guidelines (31% to 18.5%). Between 2007 and 2016, the average daily consumption of alcohol for those aged 18-24 years decreased from 20% to 12.8%. Between 2010 and 2016, the consumption of 11 or more standard drinks (very high risk) on one drinking occasion in the last year has declined among young people aged 12-17 years (7.8% to 2.8%) and 18-24 years (37.6% to 28.9%), however has increased significantly among the older age groups of 50-59 years (9.7% to 11.9%) and 60-69 years (4.8% to 6.1%). Between 2013-16, drinking in excess of the recommended lifetime risk guideline has decreased from 18.2% to 17.1%. In 2016, males were more than twice as likely as females to exceed the lifetime risk guidelines (24% and 9.8%). In 2014-15, in the HNECC PHN region, the rate of people aged 15 years and over who consumed more than two standard alcoholic drinks per day on average (20.1 per 100,000) was higher than the Australian (16.7 per 100,000) and NSW (16.7 per 100,000) rates. LGAs with the highest rates were Glen Innes Severn (27.2 per 100,000), Tenterfield (27.2 per 100,000) and Gloucester (24.9 per 100,000), and the lowest were Armidale Dumaresq (17.6 per 100,000), Great Lakes (18.3 per 100,000) and Wyong (18.3 per 100,000). In 2016, the percentage of people aged 16 years and over consuming alcohol at levels posing a long-term health risk was higher in the HNECC PHN region (33.3%) than the average for NSW (29.8%). A similar trend is observed in alcohol consumption at levels posing immediate risk, which was higher in the HNECC PHN region (30.2%) than the NSW average (27.8%). Aboriginal and Torres Strait Islander people	*Islander Online Statistics Report, Community Health and Residential Mental Health NMDS), BEACH (General Practice Activity) and the Department of Health ATAPS MDS.* *Stakeholder meetings/feedback: Public and private sector AOD service providers, peak NGO body, state government AOD office, Indigenous services.* *Stakeholder discussions/meetings, online survey of service providers, NADA planning tool.* *Alcohol consumption at levels posing long-term risk to health by PHN, persons aged 16 years and over, NSW 2016; Alcohol consumption at levels posing immediate risk to health by PHN, persons aged 16 years and over, NSW, 2016;* *Estimated number of people aged 15 years and over who consumed more than two standard alcoholic drinks per day on average (modelled estimates) (PHIDU, 2017)*

Outcomes of the health needs analysis		
	In 2016, in Australia, Aboriginal people were more likely to abstain from drinking alcohol than non-Indigenous people (31% compared with 23%). Among those who did drink alcohol, a higher proportion of Aboriginal people (35%) drank at risky levels and were at risk of harm from an alcohol related injury from a single drinking occasion at least monthly compared to non-Indigenous people (25%). About 1 in 5 (20%) Aboriginal people exceeded the lifetime risk guidelines, which was higher than the proportion for non-Indigenous people (17%). Aboriginal people were also 2.8 times more likely to drink 11 or more standard drinks monthly or more often than non-Indigenous people (18.8% compared to 6.8%). In 2016, in NSW, the proportion of Aboriginal people aged 16 years and over consuming alcohol at levels posing a long-term risk to health (44.1%) was higher than the proportion for the non-Indigenous population (29.5%) and the average for all people in NSW (29.8%). A similar trend is observed in alcohol consumption at levels posing immediate risk, which was higher for the Aboriginal population (31.7%) than the non-Indigenous population (27.7%) and the average for all people in NSW (27.8%). Between 2001-02 and 2014-15, within NSW, the rate of alcohol attributed hospitalisations amongst the Aboriginal population increased from 1,160.5 to 1,390.1 per 100,000 and was higher than the proportions for the non-Indigenous population (528.1 per per 100,000 to 639.4 per 100,000). This increased the rate difference between Aboriginal people and non-Indigenous people, widening the gap between the two populations. Between 2014-15, within NSW, the rate of alcohol attributable hospitalisations amongst the Aboriginal population was higher for males (1,795.2 per 100,000) than females (1,004.5 per 100,000). Youth Between 2005 and 2014, within the Hunter New England region, the consumption of alcohol amongst secondary school students aged 12-17 years decreased from 89.0% to 70.7%. During this period, within the Central Coast and Northern Sydney region, the consumption of alcohol amongst secondary students aged 12-17 years decreased from 88.5% to 65.4%. Co-Morbidities In 2007, in Australia, people who reported that they drank nearly every day had more than 10 times the prevalence of 12-month Substance Use disorders (10.5%) compared with people who reported that they drank less than once a month (1.0%). Almost half (49%) of the people who misused drugs nearly every day	*Alcohol consumption at levels posing long-term risk to health by Aboriginality, persons aged 16 years and over, NSW, 2016; Alcohol consumption at levels posing immediate risk to health by Aboriginality, persons aged 16 years and over, NSW, 2016; Alcohol attributable hospitalisations by Aboriginality, NSW 2001-02 to 2014-15 (Centre of Epidemiology and Evidence NSW Health; Alcohol attributable injury hospitalisations by Aboriginality, NSW 2001-02 to 2013-14 (Centre for Epidemiology and Evidence, 2016). Proportion of people aged 16 years and over, consuming more than 2 standard drinks on a day when consuming alcohol, by Aboriginality, NSW 2015, (Centre for Epidemiology and Evidence, 2016).* *Alcohol drinking in secondary school students aged 12-17 years, HNELHD, 2005 to 2014; Alcohol drinking in secondary school students aged 12-17 years, CCLHD and NSLHD 2005 to 2014 (Centre for Epidemiology and Evidence, 2016).*

Outcomes of the health needs analysis		
	had a 12-month Substance Use disorder. Data from general practices across the HNECC PHN region indicated that patients with a record of a mental health diagnosis were 1.14 times more likely to drink alcohol.	*HNECC PAT CAT data, 2017*
Illicit Drug Use	Illicit drug use is an increasing concern for stakeholders across the HNECC PHN region. Stakeholders have identified substance misuse as an issue for the Central Coast, in regards to drug consumption, opioids, smoking and alcohol; and the impact of drug and alcohol use on mental health and domestic violence. Methamphetamine use and associated issues are also reportedly increasing in the Central Coast region. In 2016, in Australia, 43% of people aged 14 years or older had used an illicit drug in their lifetime (including pharmaceuticals), 15.6% had used an illicit drug in the last 12 months, and 12.6% had used an illegal drug not including pharmaceuticals. The average age at which people first used an illicit drug was 19.7 years, which has increased since 2013 (19.3 years). In 2016, in Australia, the most commonly used illicit drugs in the previous 12 months were cannabis (10.4%), cocaine (2.5%), ecstasy (2.2%) and meth/amphetamines (1.4%). Crystal (or ice) meth/amphetamines continued to be the most common form of meth/amphetamine use. Between 2013 to 2016, in Australia, there have been significant declines in the use of meth/amphetamines (from 2.1% to 1.4%), hallucinogens (1.3% to 1.0%) and synthetic cannabinoids (1.2% to 0.3%). In 2016, the use of illicit drugs in the previous 12 months was more common among: people identifying as homosexual or bisexual; people living in remote or very remote areas; unemployed people; and Aboriginal people. Males were 1.4 times more likely to have recently used an illicit drug than females (18.3% compared with 13.0%); and people in their 20s have continued to be the most likely age group to have used an illicit drug in the last 12 months (28%). Between 2013 to 2016, in Australia, more people in their 40s used illicit drugs (13.6% to 16.2%) and there was a significant increase in recent use of any illicit drug among females aged 18 years or older (12.1% to 13.2%), mainly for females in their 30s (from 12.1% to 16.1%). Between 2001 and 2016, the largest per	*National drug strategy household survey (NDSHS) 2016- key findings (AIHW, 2017.* *Australian Institute of Health and Welfare 2017. National Drug Strategy Household Survey 2016: detailed findings. Drug Statistics series no.31. Cat. No. PHE 214. Canberra: AIHW.* *Stakeholder meetings / feedback: Public and private sector AOD service providers, peak NGO body, state government AOD office, indigenous services.* *Methamphetamine-related hospitalisations and persons hospitalised, by Aboriginality, persons aged 16 years and over, NSW 2015-16 (Centre of Epidemiology and Evidence NSW Health).*

Outcomes of the health needs analysis		
	cent change in recent use of any illicit drug was among people aged 60 or older (from 3.9% to 6.9%), followed by those in their 50s (from 6.7% to 11.7%). In 2016, 1.8 million (9.3%) of the Australian population had been a victim of an illicit-drug related incident in the previous 12 months. Hospitalisations Rates of Methamphetamine-related hospitalisations in the HNECC PHN region have increased dramatically from 2012-13 (21.1 per 100,000) to 2015-16 (143.8 per 100,000), which is higher than the state rate in 2015-16 (124.4 per 100,000). Aboriginal and Torres Strait Islander people In 2016, in Australia, compared to their non-Indigenous counterparts, Aboriginal people aged 14 years or older were 1.8 times as likely to have used an illicit drug in the last 12 months; 1.9 times as likely to have used cannabis; 2.2 times as likely to have used meth/amphetamines; and 2.3 times as likely to have misused pharmaceuticals. In NSW, the rate of Methamphetamine-related hospitalisations for the Aboriginal population has increased dramatically between 2012-13 (138.2 per 100,000) and 2015-16 (763.6 per 100,000), and remain significantly higher than the rates for the non-Indigenous population (102.8 per 100,000) and state rate for all people (124.4 per 100,000) in 2015-16. Hospitalisation rates amongst the Aboriginal population were also higher for males (885.0 per 100,000) than females (650.1 per 100,000). Co-Morbidities In 2016, in Australia, people using meth/amphetamines in the last 12 months were three times more likely to report being diagnosed with, or treated for, a mental illness compared to the non-illicit using population (42% compared to 13.9%). Between 2013 and 2016, there has been an increase in the proportion of adult drug users experiencing high or very high levels of psychological distress (10.0% compared to 11.6%), which was also observed for those who had not used illicit drugs in the last 12 months (8.6% compared to 9.7%). The increase in psychological distress over this time was most noticeable among people who had	*Methamphetamine-related hospitalisations and persons hospitalised, persons aged 16 years and over, residing in HNECC PHN, NSW 2009-10 to 2015-16 (Centre of Epidemiology and Evidence NSW Health)..*

Outcomes of the health needs analysis		
	used ecstasy in the last 12 months (18% in 2013, 27% in 2016). Data from general practices across the HNECC PHN region indicated that patients with a record of a mental health diagnosis were 8.75 times as likely to have a record of a drug abuse disorder as those without. Analysis by type of mental disorder showed that a record of a drug abuse disorder was 15.8 times as likely with a schizophrenia diagnosis recorded; 11.2 times as likely amongst patients with a bipolar disorder recorded; 5.9 times as likely amongst patients with a depression diagnosis recorded; 5.7 times as likely amongst patients with an anxiety disorder recorded; and 1.85 times as likely amongst patients with a postnatal depression diagnosis recorded.	*PAT CAT data, 2017*

Section 3 – Outcomes of the service needs analysis

This section summarises the findings of the service needs analysis in the table below. For more information refer to Table 2 in '5. Summarising the Findings' in the Needs Assessment Guide on www.health.gov.au/PHN.

Additional rows may be added as required.

Table 2

Outcomes of the service needs analysis		
Identified need	Key Issue	Description of Evidence
Drug and alcohol treatment services	At a NSW level, data regarding 'met needs' confirms alcohol, cannabis and amphetamines as the most common drugs of concern treated by substance abuse organisations. All funded Aboriginal and Torres Strait Islander substance abuse organisations reported alcohol within the top 5 most important issues and included sobering-up as a commonly provided treatment in NSW. Stakeholder engagement has confirmed that alcohol-related harm and subsequent treatment service provision remains the single largest contributing factor across the AOD sector. Stakeholder engagement has identified a number of specific Drug and Alcohol treatment service needs in the HNECC PHN region: • There are limited opportunities for treatment for individuals who have co-existing health and addiction issues. These individuals do not fit neatly into either mental health (the most common co-morbidity) or Drug and Alcohol services. Stakeholders recommend that additional Drug and Alcohol treatment capacity targets the most vulnerable individuals in society including Aboriginal and Torres Strait Islander people, people experiencing homelessness, youth and women. • A key risk point for relapse is the transition from one type of service to another, which often coincides with shifting from one provider to another. Given capacity limitations,	*AIHW (AODTS-NMDS, NOPSAD, NHMD-NMDS, Aboriginal and Torres Strait Islander Online Statistics Report, Community Health and Residential Mental Health NMDS), BEACH (General Practice Activity) and the Department of Health ATAPS MDS.* *Stakeholder meetings/feedback: Public and private sector AOD service providers, peak NGO body, state government AOD office, Indigenous services.* *Stakeholder discussions/meetings, online survey of service providers, NADA planning tool.* *Consultation with HNECC Central Coast Clinical Council, 2016.*

Outcomes of the service needs analysis		
	any gaps in support increase the risk of relapse. Service providers report significant capacity constraints for transition services and accommodation, which subsequently reduces capacity to take on new clients. • Networks between service providers are varied and are often dependent on informal communication. Systems to link providers across the various sectors such as primary care, specialist Drug and Alcohol public treatment services, the community and NGO sector would assist in service planning, including responding to emerging issues and challenges as well as pathways for the coordination of care for clients. • There is a chronic undersupply of residential rehabilitation beds across all service provider types. Various estimates put the percentage of demand being met at between 30% and 50%. Waitlists for a residential rehabilitation bed ranges from 3 to 6 months, during which time individuals are at risk of relapse. • Certain groups within the community have reduced access to, or an unwillingness to participate in, mainstream Drug and Alcohol services. An expansion of capacity for Drug and Alcohol providers that deliver targeted services, including but not limited to: Aboriginal and Torres Strait Islander peoples; homeless people; pregnant women and women with young children, would greatly increase options for vulnerable groups. This is particularly relevant to certain areas of the HNECC PHN footprint, such as the New England for example with a paucity of treatment options. • There is a need to establish accessible clinics for primary care and guidelines that are useful to address Drug and Alcohol issues in the Central Coast region. Stakeholders have identified that more promotion and support is required for services to treat substance misuse, including programs that target Aboriginal and Torres Strait Islander people, to achieve better outcomes for individuals and communities affected by alcohol and drug misuse. Survey results collected during the Mental Health and Suicide Prevention Needs Assessment, showed that 96% of service providers and consumers, carers and community members from across the HNECC PHN region agreed that drug and alcohol use contribute to mental illness;	

Outcomes of the service needs analysis		
	and 82% agreed or strongly agreed that drug and alcohol use contributes to suicide. HNECC Regional Drug & Alcohol Networks Service Mapping Survey Findings The percentage of Aboriginal clients being supported by Drug and Alcohol services ranged between 5-100%. 85.7% of services did not offer services in languages other than English. There was a low proportion of providers offering weekday evening services after 5pm (26%) and providers offering weekend day and evening services (10.5%). The number of staff employed by services varied greatly (1.5 to 200), with 36% of respondents having fewer than 10 staff. It was identified that the number of staff impacts greatly on the number of clients a service can assist, with numbers of clients ranging between 45 to over 5,000 per year. In the last 6 months, 71% of services provided drug and alcohol education and training to their staff and 23.8% were unsure of when they last participated in training. The majority of service providers strongly disagreed or disagreed that people seek help as soon as they have symptoms of drug and alcohol misuse (68.8%); strongly disagreed or disagreed that people understand the signs and symptoms of drug and alcohol misuse (75%); strongly agreed or agreed that people experience stigma associated with drug and alcohol issues which prevents them seeking help (80%); and strongly agreed or agreed that people find it difficult to travel to services they need (80%). More than half of service providers strongly disagreed or disagreed that early intervention is accessible for young people experiencing drug and alcohol issues (53.3%) and strongly disagreed that support is available for carers of someone experiencing drug and alcohol issues (60%). The majority of service providers strongly agreed or agreed that access to psychiatrists is poor (81.3%) and strongly disagreed or disagreed that the availability of drug and alcohol rehabilitation services is good (86.7%). The majority of service providers strongly agreed or agreed that factors contributing to drug and alcohol misuse in the community were family breakdown (93%); poor understanding of mental illness and its symptoms (93%); poor understanding of drug and alcohol issues and its symptoms (93%); poor access to services	*Community and clinical stakeholder engagement, 2017.* *HNECC Regional Drug & Alcohol Networks Service Mapping Survey Report (HNECC PHN, HNE LHD, CC LHD, & NADA, 2017).*

Outcomes of the service needs analysis		
	(87%); and distance to services (87%). Between 93% and 100% of service providers felt that the following preventative factors need to be present in the community to promote healthy lifestyles and reduce the uptake of drugs and alcohol: family support; a range of employment opportunities, community activities, mental health services, and drug and alcohol services; a good understanding of mental illness and its symptoms; a good understanding of drug and alcohol and its symptoms; support in the community for people experiencing drug and alcohol issues; and a focus on drug and alcohol issues by health care providers. Between 86.7% and 100% of services believed that the following factors need to be in place to improve drug and alcohol services within the community: improved coordination between services; improved access to primary drug and alcohol care services; improved access to primary mental health care services; more investment in drug and alcohol promotion and prevention; more investment in mental health promotion and prevention; increased access to early intervention services; improved quality of treatment services in the hospital system; improved follow up of patients after hospital discharge; enhanced access to community drug and alcohol services; greater access to community mental health services; improved referral to counselling services; and improved access to rehabilitation and recovery services. Service providers identified a lack of services in the Upper Hunter, Singleton and Muswellbrook region, where there are no detox and residential rehabs in this area; limited funding opportunities to run programs for clients and to acquire staff and a lack of education and counselling. Service providers reported that in the HNECC PHN region there is a need for: • more funding • more services (via probation and parole) to court mandated counselling clients and to those who have treatment as part of their parole conditions; more services for youth, family, mothers and children and ATSI; on the ground staff for local AMS health workers and skilled GPs in ambulatory detox	

Outcomes of the service needs analysis		
	• a holistic approach to treatment and a decrease in waiting lists for treatment • improved access to the hospital system and improved follow up post discharge from hospital • improved access and age appropriate services for adolescents to Drug and Alcohol services, education on Drug and Alcohol issues, more support to client and their families and day programs for women and peer support groups for families and young people • housing and accommodation and employment and skills based training • ongoing support and referral pathways for Aboriginal and Torres Strait Islander people for drug and alcohol and mental health • improved coordinated care for clients and their families, improved partnerships, access and communication between services and aftercare support services.	

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HUNTER NEW ENGLAND AND CENTRAL COAST
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HNECC PHN acknowledges the traditional owners and custodians of the lands that we live and work on as the First People of this Country.

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