



**ST VINCENT'S
HEALTH AUSTRALIA**

UNDER THE STEWARDSHIP OF MARY AIKENHEAD MINISTRIES

St Vincent's Health Australia

Submission to the NSW Special Commission of Inquiry into the Drug 'ice'

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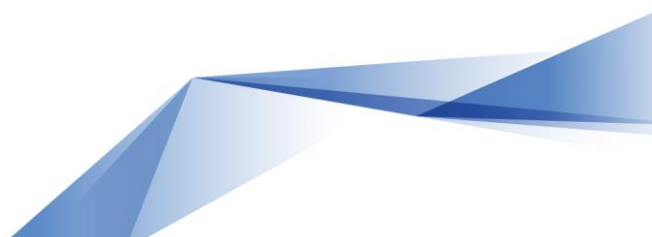
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1. Introduction

1.1 Background

St Vincent's Health Australia (SVHA) is the nation's largest not-for-profit health and aged care provider. We operate two public hospitals, 10 private hospitals and 17 aged care facilities in Queensland, New South Wales and Victoria. Along with three co-located research institutes – the Victor Chang Cardiac Research Institute, the Garvan Institute of Medical Research and St Vincent's Institute of Medical Research – we work in close partnership with other research bodies, universities, and health care providers.

SVHA has been providing health care in Australia for over 160 years, since our first hospital was established in Sydney in 1857 by the Sisters of Charity. When the first five Sisters arrived in Australia in 1838 they carried with them the vision of their Founder, Mary Aikenhead, to reach out to all in need of care and particularly to the poor and vulnerable. It is the legacy entrusted to us by the Sisters of Charity that continues to inspire St Vincent's Health Australia to strengthen and grow our mission.

SVHA employs over 19,000 staff and operates more than 2,600 hospital beds and 1,100 residential aged care places. In our hospitals, we provide more than 1 million episodes of care for patients each year.

We are a clinical and education leader with a national and international reputation in medical research. Our areas of expertise include mental health; drug and alcohol services; homeless health; prisoner health; heart lung transplantation; bone marrow transplantation; cardiology; neurosurgery; cancer; clinical genomics; HIV medicine; palliative care; respiratory medicine; and aged psychiatry.

SVHA currently proudly owns and operates over 17 aged care communities under the St Vincent's Care Services (SVCS) banner in communities across Queensland, New South Wales and Victoria. SVCS also manages (on behalf of a Religious Congregation) a residential aged care community located in Cronulla, Sydney.

Across all its aged care communities, SVCS currently provides 1,622 residential aged care beds (there are more than 200,000 residential aged care places in Australia), 330 retirement living units, 230 home care places, 175 CHSP and 61 private clients which represents support to over 2,000 elderly Australians.

1.1 St Vincent's Health Network Sydney and St Vincent's Hospital

St Vincent's Health Network Sydney (SVHNS) comprises St Vincent's Hospital Sydney (SVHS); Sacred Heart Health Service, Darlinghurst and; St Joseph's Hospital, Auburn and is part of the wider St Vincent's Health Australia (SVHA) health and aged care group of facilities.

St Vincent's Hospital in Darlinghurst is an A1 principal referral hospital providing a range of services and specialties. St Vincent's Hospital's particular areas of specialist expertise include:

- A level 6 trauma, accident and emergency service for inner city Sydney.
- Healthcare for vulnerable populations - mental health; drug and alcohol services; homeless health; prisoner health; aged psychiatry.
- Heart lung vascular services including state-wide heart lung transplant service; bone marrow transplantation / cellular therapies.
- Precision medicine including clinical genomics.
- Cancer services including through the Kinghorn Cancer Centre which is a partnership between SVHS and the Garvan Institute.

SVHNS is part of an integrated network of clinical services that aim to ensure timely access to appropriate care for all residents in NSW. As a specialist network, around half of our patients come from outside the local area for our specialist and dedicated statewide services. St Vincent's Darlinghurst is also a local hospital for residents of Sydney, Waverley, Woollahra and Randwick Local Government Areas. Within this catchment, St Vincent's serves a diverse population. Our Campus is located in an area characterized by a high incidence of homelessness and vulnerability. –

1.2 St Vincent's Hospital Sydney's Alcohol and Drug Service

St Vincent's Hospital Sydney has been a pioneer in the provision of addiction medicine services, only following its sister hospital, St Vincent's Hospital Melbourne, in establishing such services in Australia in 1971. (St Vincent's Melbourne's addiction medicine services began in 1964).

St Vincent's Hospital Sydney's Alcohol and Drug Service (ADS) comprises nearly 100 staff who work across dedicated specialist inpatient, outpatient and consultation liaison services. The service is well recognised for its high calibre clinical academic leaders, leadership and innovation in alcohol and other drug use research and service delivery.

The ADS provides an extensive range of treatment options and support for clients, both in house and across the state through its contact centre support services. Key aspects of the service include withdrawal management, pharmacotherapy treatment for opioid dependence, counselling, group programs, specialist outpatient services and hospital consultation liaison service.

In its entirety, St Vincent's Alcohol and Drug service comprises:

- Contact Centre
- Gorman Inpatient Unit
- Consultation Liaison Service
- Rankin Court Treatment Centre
- Outpatient Service
- Stimulant Services

An overview of each area is provided in Appendix 1. (page 34)

1.3 St Vincent's Hospital Melbourne (SVHM) – Department of Addiction Medicine (DoAM)

SVHAs other tertiary public hospital is situated in Melbourne. SVHM was founded in 1893, by the Sisters of Charity who were determined in their commitment to offering first-class healthcare to the community, especially marginalized and disadvantaged populations. Each successive generation of clinicians and administrators has taken up the mantle driving the growth of SVHM into the premier tertiary academic health service it is today.

The St Vincent's Hospital Melbourne (SVHM), Department of Addiction Medicine (DoAM) is one of the largest Addiction Medicine specialist units in Victoria. DoAM has been at the forefront of Addiction Medicine since establishing Australia's first alcohol dependence service in 1964. The DoAM is a key component of the Victorian State drug and alcohol response and a key opinion leader in the field of Addiction Medicine.

DoAM's mission statement is to make it easy for people to seek help for addictions. The DoAM offers a range of services designed to help patients overcome dependence on alcohol and other drugs (both illicit and prescription) and other addictions (e.g. gambling). The multidisciplinary team includes doctors who are Addiction Medicine specialists, nurses and social workers. Their work encompasses direct patient treatment, research, education, training and policy development.

The DoAM provides consultation to inpatients via a clinical liaison service, outpatient consultation services, acute inpatient withdrawal services and support to the Emergency Department over the critical weekend period. It also provides consultation and education and training sessions via telehealth and face to face with regional health services.

With expertise in the medical treatment of addiction, SVHM's DoAM is recognised for its ability to manage patients at the severe end of the addiction spectrum who often experience concomitant complex mental health issues and socioeconomic barriers that impact their ability to engage with treatment.

2. Executive Summary

2.1 How to address drug misuse from a health perspective

Given SVHA's extensive experience in supporting individuals experiencing drug misuse through our two tertiary public hospitals in Sydney and Melbourne, this Submission provides the Commission with:

- An overview of challenges and the critical focus points SVHA encourages the NSW Government to prioritise in the area of drug treatment reform
- Responses, based on our service information and service experience to the Commission Issues Papers (Use, prevalence and policy framework, health and community and data, research and funding) and
- Relevant data from St Vincent's Hospital Sydney which has informed SVHA's submission to this Inquiry. (See Appendix 1 – see pages 37-52)

Every year, up to 500,000 Australians are unable to access alcohol and other drug treatment because not enough services are available.¹ In the hundreds of thousands of Australian families where someone uses alcohol, tobacco, or other drugs in a way that hurts themselves and the people around them, life gets much harder when treatment services are not available.

This is a common experience right across the spectrum, from people who may be at risk of developing problems through to people whose use has led them to experience significant impairment or distress.

In SVHA's experience, alcohol and other drug treatment works when people can access the right kind of care at the right time, in the right place, with clinical and social support tailored to what is best for the individual.²

¹ Ritter, Alison, et al, 2014, *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, UNSW

² Lubman, Dan, et al., 2017, *Informing alcohol and other drug service planning in Victoria*, Turning Point.

Historic under-investment³, stigma⁴, uneven distribution of services⁵, poor integration with other clinical and social services⁶, a lack of evidence-based government policy and program directions, and a lack of oversight at national, state and territory levels has limited the size and effectiveness of the sector and means that too many people and their families experience long delays, little choice, and compromised quality in a system that is fragmented and difficult to navigate.⁷

The evidence informs us that the time when people access treatment is often many years later than when they should.⁸ Long delays lead to greater harm, increased health care costs⁹, and potentially less successful treatment. Poorly designed and unreliable funding systems have compounded this effect, undermining service improvement, evaluation and growth.¹⁰

SVHA does not think use of illegal drugs is good for anyone and that any interventions we make as a health system are targeted at long term withdrawal from the use of drugs. While recognising the Special Commission of Inquiry is concerned with 'ice', from a health and treatment perspective we believe that to address this *issue we must first focus on some large-scale reforms that will benefit people who want and need treatment for problematic substance use of all types*. The three priorities for reform are:

1. **Improving the size and focus of investment** – we urge the NSW Government to work with the Commonwealth and other states and territories to dramatically increase funding to severely underfunded alcohol and other drug treatment services.

The alcohol and other drugs treatment sector is one of the last sectors not to utilise a national evidence-informed planning framework to guide and plan public investment.

We recommend that all governments use needs-based population planning to ensure that investment in treatment is targeted, and delivered in those areas, and to those groups of people who most need it.

³ Ritter, Alison, et al, 2014, *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, UNSW

⁴ Lancaster, Kari, 2017, *Reducing stigma and discrimination for people experiencing problematic alcohol and other drug use*, Queensland Mental Health Commission.

⁵ Ritter, Alison, et al, 2014, *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, UNSW

⁶ Lubman, Dan, et al., 2014, *A study of patient pathways in alcohol and other drug treatment*, Turning Point

⁷ Lubman, Dan, et al., 2014, *A study of patient pathways in alcohol and other drug treatment*, Turning Point

⁸ Chapman, C, et al., 2015, 'Delay to first treatment contact for alcohol use disorder' in *Drug and Alcohol Dependency*; Lee, Nicole, et al., 2012, 'Examining the temporal relationship between methamphetamine use and mental health comorbidity', in *Advances in Dual Diagnosis*.

⁹ Ettner, SL, et al., 2006, 'Benefit-cost in the California treatment outcome project: does substance abuse treatment "pay for itself"?', in *Health Services Research*

¹⁰ Ritter, Alison, et al, 2014, *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, UNSW

2. **Development of a national strategic plan for the alcohol and other drug treatment system** - inequitable distribution of treatment services means that some population groups and communities, including regional and rural communities, experience particularly severe lack of access. Further, the division of responsibilities between the NSW Government (and other state and territory governments), and the Commonwealth requires clarification and improved coordination. We believe such a plan would help deliver greater impact across the treatment services sector.
3. **Invest in service and workforce capability** – the NSW Government should work with the Commonwealth and the states and territories to create and contribute to an alcohol and other drug treatment sector capability fund. This would address immediate needs by investing in service improvement and evaluation; expanding the specialist alcohol and other drug treatment workforce; and in capital works to improve the physical infrastructure of services. This fund must also include a focus on further developing the Aboriginal and Torres Strait Islander workforce and a peer workforce – both of which are especially required in alcohol and drug treatment services.

Underneath these high level areas of reform, there are a range of other activities, specific to treatment services that assist stimulant users, which we recommend be addressed in NSW. These recommendations sit across the responsibilities of the state and commonwealth governments:

- More resources to encourage early treatment (eg: SVHS's S-Check program). People who use Amphetamine Treatment Services (ATS) don't recognise they have a problem until it's too late. They often self-medicate withdrawal and believe treatment services are for other drug users. Although problems develop early (usually six-seven months from first regular use), treatment seeking is usually delayed between five-10 years, during which time severe mental and other health problems emerge.
- Expand 'access out of hours' and 'out of area' treatment through new technologies.
- Ensure GPs have capacity for early detection, brief intervention and referral for severe substance use disorder, this includes training, referral networks, and financial incentives through Medicare rebates.
- Ensure there are adequate numbers of specialist medical practitioners for referral from primary care. This will require expansion of specialist treatment places, as well as specialist medical and nursing workforce capacity building, including a review of the current Medicare rebates for specialist addiction medicine practitioners.
- Expand specialist outpatient services to enable access to prompt treatment and to provide post-withdrawal care and support, including a network of rural specialist multidisciplinary services/hubs.

- Ensure there is adequate funding for the range of specialist withdrawal and post-withdrawal services, including hospital inpatient and outpatient services and outpatient and residential post-withdrawal continuing care
- Ensure there is adequate funding for extended-hour hospital alcohol and drug consultation-liaison services, to provide treatment to people presenting to emergency departments and admitted to hospital with other conditions.
- A sustained and comprehensive stigma reduction strategy to improve community and service understanding towards stimulant use – particularly methamphetamines – and enable affected individuals to seek treatment and help.
- Engage the media to improve its reporting on stimulant and methamphetamine use. Currently media is creating a climate of fear and panic which is against public-health interests; stigmatises users; and by influencing the public to think its use is more common than it is, risks contributing to a normalisation in the community. New national guidelines released by Mindframe in March 2019 should be used as a guide by media to ensure balanced reporting.¹¹
- People who use methamphetamine and other ATS generally use other substances as well, and a single drug strategy may prove to be counterproductive from a supply, demand and harm reduction perspective.
- Any harm reduction or stigma reducing campaign(s) developed must be developed with and for affected and at-risk communities (indigenous, youth, rural/regional, LGBTQI); and include effective public health messages about other substances and not just meth/amphetamine.
- Adequate research funds for novel interventions for the treatment of methamphetamine dependence, including agonist pharmacotherapies that have been shown to have promise or are under investigation such as lisdexamfetamine.
- Support for the development of programs and resources that minimise health harms associated with ATS used through sexual health services, HIV services, peer workers, drug user groups, needle-syringe programs, primary care and general practice.
- Piloting of Multidisciplinary Regional services/hubs to provide alcohol and other drug treatment support to people living in rural and remote parts of NSW.

¹¹ <https://mindframe.org.au/alcohol-other-drugs/communicating-about-alcohol-other-drugs/mindframe-guidelines>

3. Matters raised by Inquiry's Issues Papers

3.1 Use, Prevalence and Policy Framework Issues Paper 1

The use of illicit drugs is prevalent across the Australian population. National surveys have revealed approximately 1 in 8 Australians have used an illegal substance in the last 12 months. The most commonly reported illegal drug was cannabis, followed by cocaine, ecstasy and meth/amphetamines.¹²

Substance use disorders constitute a multi-factorial public health issue, with evidence suggesting they are associated with poor health outcomes, premature death and disability, poverty, violence, criminal behaviour, and social exclusion.¹³ In the Australian population aged 14 years and above, lifetime use of any illicit drug has increased from 38% in 2001, to 43% in 2016; with about 15.6% of those surveyed reporting use of an illicit drug in the past 12 months.¹⁴

Despite limited reported use among the Australian public (approx. 0.3 per cent), the Australian Institute of Health and Welfare has signaled a rapid growth in the availability of new and emerging psychoactive substances (NPS).¹⁵ Internationally, NPS use (particularly of fentanyl analogues) has been found responsible for a rising number of overdoses and fatalities. The 2017 United Nations World Drug Report warns pills and powders containing synthetic opioids pose a significant threat to public health the emergence of new substances belonging to highly diverse chemical groups.¹⁶

In alignment with national findings, across NSW substance use is widespread, and related presentations to hospitals and health services are high. Within some hospitals, it has been estimated more than 35 per cent of admitted patients have a substance use issue.¹⁷

¹² AIHW (2017). National Drug Strategy Household Survey 2016: Detailed Findings.

¹³ United Nations Office on Drugs and Crime. World Drug Report 2017. Vienna: United Nations.

¹⁴ Australian Institute of Health and Welfare. National Drug Strategy Household Survey 2016: detailed findings. Canberra: AIHW; 2017.

¹⁵ Ibid

¹⁶ UN Office on Drugs and Crime (2017). World Drug Report 2017

¹⁷ Reeve, R., Arora, S., Viney, R., et al. (2014). Evaluation of NSW Health Drug and Alcohol Consultation Liaison Services Sydney: Centre for Health Economics Research and Evaluation (CHERE), University of Technology, NDARC, UNSW

In addition to high rates of substance use and hospital presentations, state plans and reports have revealed a high unmet need for alcohol and drug treatment services across the state. NSW Health has estimated between 26 to 46 per cent of all people who seek treatment, and are appropriate to receive treatment, are able to access services.¹⁸

Alongside national reports, NSW has experienced a significant increase in hospitalisations and ED presentations related to use of crystal methamphetamine since 2009.^{19,20}

Findings from the Illicit Drug Reporting System (IDRS) indicate use of cannabis and pharmaceutical opioids has remained relatively stable, while NPS use remains low. Other findings suggest the use of ecstasy pills is on the decline, while use of capsules and crystal is increasing.^{21,22}

State surveys have also revealed high levels of self-reported risks and harms. Approximately a quarter of IDRS survey respondents indicate having experienced a non-fatal overdose in the past year, while 1 in 10 respondents reveal having been previously resuscitated by someone who participated in a naloxone program.²³

In 2016, the crystalline form of methamphetamine was the most commonly reported methamphetamine used, increasing from 22% in 2010 to 57% in 2016. While overall rates of methamphetamine use have remained stable in recent years, existing methamphetamine users are reporting higher rates of regular and dependent use; with daily and weekly use of methamphetamines among users up from 9.3% in 2010 to 20% in 2016.²⁴

The costs of methamphetamine to the Australian community are estimated at \$A5 billion annually, excluding the costs of Federal policing, Federal courts, and border protection.²⁵

¹⁸ Reeve, R., Arora, S., Viney, R., et al. (2014). Evaluation of NSW Health Drug and Alcohol Consultation Liaison Services Sydney: Centre for Health Economics Research and Evaluation (CHERE), University of Technology, NDARC, UNSW

¹⁹ Gibbs, D., & Peacock, A. (2018). New South Wales Drug Trends 2018: Key findings from the Illicit Drug Reporting System (IDRS) Interviews. Sydney, NDARC, UNSW

²⁰ HealthStats NSW (2018) Methamphetamine-related Emergency Department presentations

²¹ Gibbs, D., & Peacock, A. (2018). New South Wales Drug Trends 2018: Key findings from the Ecstasy and Related Drugs Reporting System (EDRS) Interviews. Sydney, National Drug and Alcohol Research Centre, UNSW

²² Gibbs, D., & Peacock, A. (2018). New South Wales Drug Trends 2018: Key findings from the Illicit Drug Reporting System (IDRS) Interviews.

²³ Ibid

²⁴ Degenhardt L, Larney S, Chan G, Dobbins T, Weier M, Roxburgh A, et al. Estimating the number of regular and dependent methamphetamine users in Australia, 2002-2014. *Medical Journal of Australia*. 2016;204(4):153.

²⁵ Whetton S, Shanahan M, Cartwright K, Duraisingam V, Ferrante A, Gray D, Kaye S, Kostadinov V, McKetin R, Pidd K, Roche A. The Social Costs of Methamphetamine in Australia 2013/14.

Methamphetamine is responsible for the second highest disease burden related to illicit drug use. Population reports indicate a large increase in use of the drug, alongside an increase in drug purity and availability. In 2017, the number of deaths related to use of methamphetamine and other stimulants was four times higher than that in 1999.²⁶

Between 2013 and 2016, the National Drug Strategy Household Survey (NDSHS) found an increase in the proportion of people reporting mental illness who used methamphetamine (from 29% to 42%), ecstasy (from 17.9% to 27%) and cocaine (from 17.4% to 25%) in the previous 12 months.²⁷ Regional and rural areas and younger drug users are also disproportionately affected.²⁸

While the reported consumption of methamphetamine decreased among the general population from 2.1% in 2013 to 1.4% in 2016,²⁹ results indicate that methamphetamine users are doing so with increased frequency: between 2010 and 2016 the daily and weekly use of methamphetamines more than doubled; and daily and weekly use among people who reported mainly using crystal/ice increased from 12.4% in 2010 to 25% in 2013 and to 32% in 2016.³⁰

In fact, the estimated weight of methamphetamine consumed annually by Australians increased from 8,405 kg to 9,847 kg between August 2016 and August 2018.³¹ Globally Australia is reported to have the highest prevalence of use of methamphetamine.³²

The high use of stimulants in Australia reflects a number of factors including marketing decisions made by illicit operations, the ease of production of synthetic compounds compared to plant based drugs, the prevalence of local manufacture, the availability of other drugs, and the acceptance and normalisation of ATS as a party drug. This pattern is not dissimilar to previous illicit drug waves that we as a community have experienced, and will again surface when new synthetic and designer substances potentially substitute ATS.

²⁶ AIHW (2018). Alcohol, tobacco & other drugs in Australia

²⁷ Australian Institute of Health and Welfare. National Drug Strategy Household Survey 2016: detailed findings. Canberra: AIHW; 2017.

²⁸ Claydon, C., Webber, K. and Sweeney, J. National Drug Strategy Household Survey 2016: detailed findings. 2017

²⁹ Australian Institute of Health and Welfare, Alcohol, tobacco & other drugs in Australia, web report, Dec 2018.

³⁰ Australian Institute of Health and Welfare. National Drug Strategy Household Survey 2016: detailed findings. Canberra: AIHW; 2017.

³¹ National Wastewater Drug Monitoring Program Report 6, December 2018

³² O'Brien, J., Grant, S., Mueller, J., Tscharke, B., Gerber, C. and White, J. National Wastewater Drug Monitoring Program-Report 1. 2017

ATS use, particularly chronic use, can cause a broad range of physical, psychological and social harms. All of these issues are interconnected and related and are felt by more than just the individual user of the drug, they impact upon the family unit, friends, co-workers and members of the general community.

It is our experience – and this includes both users and their family members – that people with complex ATS-related health or mental health issues also have significant social impacts including involvement in criminal activity; loss of employment, income and productivity; loss of accommodation; increased reliance on health treatment and social welfare support; impaired family and other interpersonal relationships. The social impacts of the drugs on family and friends can be devastating, including family trauma and violence and child endangerment. There are also issues pertaining to the use of ATS and driving (particularly amongst transport workers) and its contribution to road trauma.

Methamphetamine use is often in the context of other substance use, termed poly-drug use. Research shows that a high number of methamphetamine users (92 per cent) use at least one other illicit drug type in the past 12 months. The most commonly cited drug used in combination with methamphetamine was alcohol at 86 per cent, followed by cannabis (72.7 per cent). This was then followed by ecstasy (53 per cent), cocaine (39.5 per cent) and pharmaceuticals for non-medical purposes (34.7 per cent).³³

There may be additive toxic effects of methamphetamine which need to be effectively addressed in health contexts. It is important, therefore that when trying to understand and implement strategies to manage the impact on the individual and the community, recognition needs to be given to other substances in addition to meth/amphetamine.³⁴

Failure to recognise the prevalence and patterns of poly-drug use can have significant consequences for public health, law enforcement and community safety programs. A single drug strategy can prove counterproductive if the use of one drug type is inextricably linked to the use of other drugs within the local drug market.

The extent that methamphetamine users concomitantly use alcohol and cannabis at high rates may have implications for drug treatment interventions and programs targeting methamphetamine use.

³³ AIHW 2014. National Drug Strategy Household Survey detailed report: 2013. Drug statistics series no. 28. Cat. no. PHE 183. Canberra: AIHW.

³⁴ McKetin R; Kelly E; McLaren J, 2006, 'The relationship between crystalline methamphetamine use and methamphetamine dependence.', *Drug and Alcohol Dependence*, vol. 85, no. 3, pp. 198 - 204, <http://dx.doi.org/10.1016/j.drugalcdep.2006.04.007>

Similarly, the extent that other stimulant drugs, including new psychoactive substances, are potential substitutes or additives to methamphetamine has significant implications for health responses as well as the supply reduction and drug market interdiction activities of police.

The concept of poly-drug use and its effects on the user and his or her community, must therefore, be factored into any discussion of methamphetamine use and its consequences.

There is a proportion of people from particular population cohorts that are using more frequently and using the more potent crystalline form of methamphetamine which is associated with growing health and social harms.

Methamphetamine users represent a diverse cross-section of society; however, the population cohorts that we have identified as being particularly at risk are young people, Aboriginal and Torres Strait Islander people, the LGBTQI community, and those living in rural and remote communities.

Aboriginal and Torres Strait Islanders

There are increasing problems related to methamphetamine use in Aboriginal and Torres Strait Islander communities throughout Australia and NSW, particularly the significant harms it causes when used with other drugs concurrently. There is an over-representation of Aboriginal and Torres Strait Islanders in St Vincent's Sydney alcohol and other drug services.

During the year 2016-17, 13 per cent of episodes at St Vincent's Sydney's Gorman Unit identified as Aboriginal and/or Torres Strait Islander.

Of active outpatient clients of the hospital's alcohol and other drug service, 7 per cent (n=29) identified as Aboriginal or Torres Strait Islander.

St Vincent's Sydney's Stimulant Treatment Program has received frequent requests from Aboriginal Medical Services around NSW to train workers and talk with communities about methamphetamine interventions.

According to available data on self-reported use of illicit substances, methamphetamine is the third most common illicit substance used in Aboriginal and Torres Strait Islander communities, with 5 per cent indicating amphetamines/speed use in the 12 months prior to the survey.³⁵ In 2016, Indigenous Australians were 2.2 times more likely to use methamphetamines than the general population.³⁶

Some of the adverse consequences stemming from drug use and dependency voiced from these communities include domestic violence, tensions from sourcing money for substance use, declining participation in community life, child neglect and sexual exploitation of young people.

Lesbian, Gay, Bisexual, Trans, Queer and Intersex (LGBTQI) communities

There are significantly higher rates of illicit drug use among LGBTQI people compared to heterosexuals. The 2007 and 2010 NDSHS showed illicit drug use among LGB people to be much higher than the rest of the population, including methamphetamine use (almost five times higher among men and more than three times higher among women), and cocaine use (three times higher among men and six times higher among women) in the 2007 survey.³⁷

The Sydney Gay Community Periodic Survey (SGCPS), a biannual, Sydney-based survey focused on gay and other homosexually active men's sexual and drug use, and the Sydney Women and Sexual Health Survey (SWASH), a biennial survey addressing women's general and sexual health, both indicate significantly higher rates of substance use across all substance types.³⁸

The high rates of stimulant use, particularly among gay and bisexual men – and often associated with potentially risky sexual practices – indicate there should be a particular focus of targeted harm reduction and combined harm reduction and sexual health services for this community.

Young people

Among young people who use methamphetamine, the average age of initiation is 18.6 years.³⁹ Young people are not currently being attracted into treatment for substance use, despite evidence of first onset psychoses being linked to methamphetamine use among younger people. Expanding use of technology (eg: mobile, online, videoconferencing, and

³⁵ Australian Institute of Health and Welfare (AIHW) 2011, Substance use among Aboriginal and Torres Strait Islander people, AIHW, Canberra.

³⁶ Australian Institute of Health and Welfare. National Drug Strategy Household Survey 2016: detailed findings. Canberra: AIHW; 2017.

³⁷ ACON Health Outcome Strategy 2013-2018 Alcohol and Other Drugs

³⁸ ACON Health Outcome Strategy 2013-2018 Alcohol and Other Drugs

³⁹ Australian Institute of Health and Welfare. National Drug Strategy Household Survey 2013

telephone-based interactive voice response) to connect, communicate, and engage with young people shows promise and acceptability among this group.

Methamphetamine use has been declining since it peaked at 13.2% for 18–24 year olds in 2001 and significantly declined between 2013 and 2016. This decline was mainly driven by a substantial decline among people in their 20s—recent use of meth/amphetamines halved among this age group between 2013 and 2016 (from 5.7% to 2.8%) for both males (6.7% to 3.3%) and females (4.8% to 2.2%).⁴⁰

Rural/regional/remote

People in rural and remote areas find it difficult to get to a GP, pharmacist or medical specialist.⁴¹ The health challenges faced by people who live in rural and regional Australia are generally greater than for those living in major cities. While there have been improvements in health care delivery, people living in rural and regional communities experience poorer health outcomes than those living in metropolitan communities. This is also true for people in these parts of the nation experiencing alcohol or other drug use disorders.

Following are the stark realities for people living in rural and regional Australia:

- Illicit drug use is most prevalent for people in remote and very remote areas as outlined in the latest available NDSHS (2016) which shows that: people in remote and very remote areas (25%) were more likely to have used an illicit drug in the last 12 months than people in major cities (15.6%), inner regional areas (14.9%) and outer regional areas (14.4%); and
- The same report states that people living in remote and very remote areas were 2.5 times more likely than those from major cities to have used methamphetamine (3.5% compared with 1.4%).
- Data from the National Hospital Morbidity Database (2016-17) also indicates people from remote and very remote areas of Australia are receiving hospital care for methamphetamine-related problems at a higher rate than people from capital cities.

We know there are significant issues with people who have drug problems being unable to access services they need in rural and regional Australia. We also need to address the gaps in the data and information available relating to unmet demand in rural and regional local communities to be able to improve the planning, resourcing and delivery of services in these areas.

⁴⁰ Australian Institute of Health and Welfare; Alcohol, tobacco & other drugs in Australia Web Report, December 2018.

⁴¹ Swerissen H, Duckett S, Moran G. Mapping primary care in Australia. Grattan Institute; 2018.

Services that are accessible and available to a client when they require them and are willing to engage with them, is critical to successful patient outcomes.

A greatly enhanced model of care goes well beyond residential rehabilitation places to radically expand the breadth of service provision.

Evidence-based patient-centred treatment responses are urgently needed in rural and regional Australia. Multidisciplinary services/hubs, with flexible and responsive delivery, supported by experienced treatment providers would dramatically improve this situation.

We propose that progress towards the above could be achieved by the development and implementation of Multidisciplinary Regional services/Hubs that would include:

- Value-add projects to build on existing regional service infrastructure;
- Building on investment under Commonwealth initiatives such as the National Ice Action Strategy into Primary Health Networks (PHNs) for drug and alcohol treatment services;
- Using a mix of new technologies and face-to-face service to provide access to expert specialist multidisciplinary care that is often lacking in rural and regional areas;
- Supporting local clinicians to provide care and therapeutic case management, coordinated by an Integrated Care Coordinator;
- Building local clinical research capacity embedded in the services/hubs; and
- Monitoring and evaluating new approaches, so the sector and patients benefit across the country from evidence-based treatments.

Our proposed approach would ensure the engagement and upskilling of local AOD workforces, the provision of ongoing care advice for patients, and a link between primary healthcare providers and specialist drug and alcohol clinicians.

Multidisciplinary Regional Hubs would work with a local team taking on the role of engaging people in care, while a specialist team would provide the specialist back-up and consultations, (face-to-face and telehealth) as well as training and capacity building.

The local team would provide primary care, or generalist drug and alcohol care, and therapeutic case management, depending on the existing capacity. The local team will provide a mix of face-to-face care, engage patients, provide early intervention and therapeutic case management for more complex presentations, and work with networks of local services including aboriginal health services, youth services and social services.

3.3 Health and Community Issues Paper 2

We have addressed the impacts of stimulant use, both on users and their families/loved ones, and SVHA's experiences of stimulant use among specific populations elsewhere in this submission.

Treatment Services

We define 'treatment' as an intervention that changes an individual's drug-using behaviour.

In NSW, drug treatment services are normally provided within dedicated alcohol and/or drug treatment services or within generalist healthcare settings with specialist staff, such as hospital-based withdrawal, or medically-assisted treatment for opiate dependence in primary care settings.

Specialist drug treatment services typically includes:

- Drug withdrawal (detoxification);
- Counselling, psychotherapy, cognitive behavioural therapy and support;
- Residential rehabilitation;
- Medication-assisted treatment, including medically assisted treatment for opioid dependence, and other maintenance medications;
- Aftercare/ongoing care/continuing care; and
- Comprehensive assessment and case management as part of all of the above treatment types.

This distinguishes specialist treatment from other services that also have a role in promoting well-being among people who use drugs such as generalist health care, mental illness treatment, welfare and social services, and primary care interventions.

The number of people receiving drug treatment from publically funded AOD treatment agencies across Australia:

- 127,404 clients in treatment (closed episodes, unique individuals). Of these amphetamines comprised 26% of all treatment episodes (alcohol 32%, cannabis 22% and heroin 5%).⁴²
- 34,000 clients receiving medication-assisted treatment. All of these were for opioids (the majority heroin).⁴³

⁴² Alcohol and other drug treatment services in Australia 2014–15, National Minimum Data Set 2, Australian Institute of Health and Welfare

⁴³ National opioid pharmacotherapy statistics (NOPSAD) 2016, Australian Institute of Health and Welfare

Of service providers:

- 836 publicly-funded alcohol and other drug treatment agencies.⁴⁴
- 1,472 authorised prescribers of opioid pharmacotherapy drugs with 2,011 dosing points (excluding Victoria and the ACT).⁴⁵

Involuntary/mandatory treatment

There is limited scientific literature evaluating compulsory drug treatment. However, the available evidence does not, on the whole, suggest improved outcomes related to compulsory treatment approaches, with some studies suggesting potential harms.⁴⁶

As a long-term provider of alcohol and other drug treatment services, we believe that mandatory treatment further stigmatises alcohol and other drug users. Such stigma is a major impediment to people seeking help for their health problem. It's partly why methamphetamine users often wait up to 10 years from when they first start having problems related to their drug use, and seeking treatment.

A far more effective use of scarce resources is to make sure that people in NSW who are seeking treatment voluntarily have the range of treatment services available and accessible to help when they are needed.

Treatment services and ATS

Despite the numerous health and social consequences resulting from methamphetamine dependence, treatment coverage is low and access of treatment delayed.

Psychosocial treatments are moderately effective, although treatment outcomes are poorer once use has become frequent (every second day or more).^{47 48 49} Yet people who use methamphetamine are typically not attracted into treatment, with the average treatment delay up to 10 years from first experiencing problems associated with use.⁵⁰

⁴⁴ Alcohol and other drug treatment services in Australia 2014–15, National Minimum Data Set 2, Australian Institute of Health and Welfare

⁴⁵ National opioid pharmacotherapy statistics (NOPSAD) 2016, Australian Institute of Health and Welfare

⁴⁶ International Journal of Drug Policy, *The Effectiveness of Compulsory Drug Treatment: A Systematic Review*, D Werb, et al; 2016 Feb; 28: 1–9.

⁴⁷ Lee NK, Rawson RA. A systematic review of cognitive and behavioural therapies for methamphetamine dependence. *Drug and alcohol review*. 2008;27(3):309-17.

⁴⁸ Baker A, Boggs TG, Lewin TJ. Randomized controlled trial of brief cognitive-behavioural interventions among regular users of amphetamine. *Addiction (Abingdon, England)*. 2001;96(9):1279-87.

⁴⁹ Hillhouse MP, Marinelli-Casey P, Gonzales R, Ang A, Rawson RA. Predicting in-treatment performance and post-treatment outcomes in methamphetamine users. *Addiction (Abingdon, England)*. 2007;102(s1):84-95.

⁵⁰ Lee NK, Harney AM, Pennay AE. Examining the temporal relationship between methamphetamine use and mental health comorbidity. *Advances in Dual Diagnosis*. 2012;5(1):23-31.

A range of services is required to both promote earlier presentation for treatment, and to engage those who would benefit from treatment but are not accessing care. Typically services are provided across the spectrum of substance use disorder – from early occasional use that puts the individual at risk of harm (risky use), through to regular compulsive use despite the experience of harm (dependence). The most severe end of the spectrum is known as severe substance use disorder or dependence which is characterised as a chronic relapsing condition but which is far less prevalent than less severe substance use disorder.

Substance use disorders are health conditions and most presentations can and should be managed in primary care. Severe problems require referral to specialist services, such as intensive case management, specialised counselling, inpatient withdrawal, post-withdrawal care, and pharmacotherapies. At times people present with acute withdrawal or toxic effects to emergency departments, or seeking treatment in the mental health system for coexisting mental disorders. Residential rehabilitation can provide some respite for families and the small proportion of individuals at the severe end of the spectrum.

It's important that harm reduction strategies be delivered by health care professionals that are also outside the alcohol and other drug sector; this is because ATS users often prefer to seek assistance from non-alcohol and other drug services such as primary health practitioners.

The role of Primary Health Networks, primary health practitioners, and community health centres cannot be underestimated in their ability to promote harm reduction and provide education to clients.

They are also pivotal partners for treatment services because they act as points of engagement and entry into specialist treatment, as well as, sources of aftercare and support to prevent relapse. In this way, ATS-using clients are not left to navigate the system on their own, but the onus is on treating professionals and services to develop pathways and provide sources of harm reduction advice.

However, most GPs and multidisciplinary healthcare providers in primary care are still not skilled-up to detect and respond to substance use disorders. As a result, every year, between 200,000 and 500,000 Australians are unable to access alcohol or other drug treatment.⁵¹ This is a common experience right across the spectrum, from people with emerging problems through to people with chronic conditions including dependence.⁵²

⁵¹ Ritter A, Berends L, Chalmers J, Hull P, Lancaster K, Gomes M. New Horizons: The review of alcohol and other drug treatment services in Australia, Final Report. Sydney: The University of New South Wales National Drug and Alcohol Research Centre; 2014.

⁵² Swerissen H, Duckett S, Moran G. Mapping primary care in Australia. Grattan Institute; 2018.

There is a need to upskill the generalist health workforce if we are to achieve and sustain effective responses to ATS use and dependence (eg: poly drug use, behavioural and psychological disturbances), as well as, provide them with early brief intervention tools to manage and prevent harm.

Greater funding for treatment places and training of generalist and specialist psychologists, social workers, and trained counsellors is required to expand treatment places.

Pharmacotherapy and ATS

Urgent high quality research is also required to explore the effectiveness of emerging candidate drugs for the treatment of severe dependence, particularly agonist pharmacotherapies which show promise.

St Vincent's Hospital Sydney is leading a research trial to test whether the drug lisdexamfetamine – commonly prescribed for Attention Deficit Hyperactivity Disorder (ADHD) in children – can reduce cravings and withdrawal symptoms among people with severe methamphetamine dependence.⁵³

The drug, often referred to as 'lisdex', is a brain stimulant and mimics the effects of methamphetamine.

The new trial, expected to take at least two years, is being held at four treatment centres in Darlinghurst and Mt Druitt in Sydney, Newcastle and Adelaide and involves 180 participants.

It is a randomised double-blind placebo-controlled study, which means that one group receives lisdex while another receives a placebo, in addition to counselling. Results from the two groups will then be compared.

A number of different medications have been tested previously to address methamphetamine dependence but failed to prove effective.

The hope is that lisdex will help methamphetamine users in a similar way to how nicotine replacement therapy supported smokers and methadone helped heroin users.

Specialist stimulant treatment

In the absence of a pharmacological intervention, seeking early intervention is a key priority if we are to engage people who use stimulants and effect change in behaviour.

As such, it is necessary that we continue to expand and disseminate early intervention models such as St Vincent's Sydney's S-Check Clinic.

⁵³ <https://limastudy.info/>

Initiatives such as S-Check are only going to be effective if there are adequate numbers of specialist stimulant treatment places available to refer people to who need treatment. There should be both specialist stimulant treatment programs (to take a leadership and training role), as well as, increased numbers of stimulant treatment places in all drug and alcohol services around the country.

In addition, research indicates that stimulant users are more likely to seek help from a specialist clinic that provides treatment unique to their dependence, rather than being treated in the broader alcohol and other drug system, which has been found to be a barrier in seeking treatment and retaining such clients.⁵⁴

Providing information about risks and strategies to reduce harms may be the most appropriate intervention for specific groups of ATS users, particularly young people, people living in rural and remote communities, Aboriginal and Torres Strait Islander peoples and Gay Lesbian Bisexual and Transgender communities.

Harm reduction interventions that address high risk sexual activity, preventing transition to injecting, educating individuals with a pre-existing psychotic illness, such as schizophrenia, all need to be considered. Therefore services and programs that promote HIV testing, sexual health, safe-substance use, Aboriginal Health Services, alcohol and drug services and sexual health services require enhanced funding and support, if as a community we are serious about reducing the potential harms associated with ATS use.

In addition to this, and as noted earlier, given the reluctance of many methamphetamine users to attend traditional treatment services, their relatively young age and the patterns of use, it makes sense that 24 hour telephone and internet support services, as well as, technology-based interventions be considered as alternative early intervention priorities.

Each state currently has a telephone information service – ready access to these services could be unified through a single national number and can facilitate anti-stigma reporting in the media and promote treatment seeking.

Drug treatment works when people can access the right kind of care at the right time; with clinical decisions tailored to what is best for the individual. Australian families consistently tell us they experience enormous distress and suffering through long delays in getting assistance, little choice in what help they can access, and compromised quality in a system because it is fragmented, extraordinarily difficult to navigate, and sometimes too expensive for them to afford. (eg: not bulk billed, requiring co-payment, limited to 10 sessions).

⁵⁴ http://www.turningpoint.org.au/Media-Centre/Latest_News/-Methamphetamine-clinics-provide-new-hope-.aspx

These long delays lead to greater harm, increased health care costs, and potentially less successful treatment. Poorly designed and unreliable funding systems have compounded this effect, undermining service improvement, evaluation and growth.

Greater strategic investment would build the capacity of the sector, particularly in areas such as rural and regional NSW, to begin to reduce the impact of methamphetamine and other drug use on individuals, families, and local communities.

In the 21st century, flexible models are better suited to meet the needs of people with substance use disorders, where and when they need them.

Barriers to treatment⁵⁵

Based on work by Professor Alison Ritter and Michala Kowalski from the Drug Policy Modelling Program, barriers to treatment fall into five main categories:

1. Social factors
 - Stigma
 - Shame, fear of being judged as a major barrier to treatment
 - Fear of children being taken away
 - Stereotypical views of clients of alcohol and other drug treatment (eg: 'I am different from the people who get treatment')
 - Cultural sensitivity
2. Treatment accessibility factors
 - Not enough treatment services
 - Waiting lists
 - No service available in area ("distance")
 - Treatment is not the kind they wanted or did not suit their needs
 - Restrictive entry requirements (and being "banned")
 - Client doesn't fit the criteria for service entry
 - Difficulties in finding assistance for complex vulnerabilities, especially at times of crisis.
 - A lack of guidance on how to navigate the many agencies
3. Within treatment factors
 - Lack of skilled staff
 - Poorly resourced
 - Rules and regulations for some treatment types
 - Concern about religious flavour

⁵⁵ Australian qualitative research on barriers to treatment, Alison Ritter and Michala Kowalski, Drug Policy Modelling Program, March 2018

- No ability to have children in treatment
 - Beliefs about treatment
 - Lack of holistic or comprehensive services
 - Fragmentation of services
 - Lack of confidence in treatment effectiveness
 - Services not adequately engaging with family
 - Unsuitable appointment times
 - Short duration
 - Lack of access to aftercare
 - Gender issues (gendered treatment)
 - Treatment as 'addictive'
 - Disrespectful staff, lacking in empathy, discriminatory
 - Lack of cultural competency among formal help sources
4. Personal and psychological factors:
- Notions of self-reliance (eg: 'I can handle it on my own')
 - Privacy and confidentiality concerns
 - Fear of job loss
 - Family opposition
 - Lack of problem-awareness ('denial')
5. Practical barriers
- Cost of treatment (across all treatment types, including dispensing fees, but also residential)
 - Fees and other costs associated with treatment
 - Childcare options outside treatment
 - Travel constraints, transport issues
 - Time
 - Lack of awareness of treatment options ("didn't know where to go")

Treatment service reform

The quality and availability of alcohol and drug treatment is limited by funding, insufficient coordination between the different levels of government that are commissioning treatment services, a lack of accountability and transparency for treatment service outcomes, fragmentation of the service system, poor integration with other clinical and social services, stigma and discrimination related to alcohol and other drug problems, and insufficient workforce development.

1. Funding

Insufficient and short-term funding has been a constant barrier to longer-term investment in alcohol and other drug treatment infrastructure and services and to recruiting and retaining a specialist workforce.⁵⁶

We recommend that governments across Australia improve the size and focus of investment in the alcohol and other drugs treatment sector and use needs-based population planning and relevant national and state frameworks to ensure that increased investment in treatment is targeted and delivered in those areas and to those groups of people who need it most.

The last comprehensive analysis of alcohol and drugs treatment funding was during 2012–2013 and identified that \$1.2 billion was spent on treatment services annually to meet the needs of up to 234,000 people. Given that estimates of up to 500,000 Australians would be in treatment if places were available⁵⁷, it's estimated that at least an additional \$1.2 billion per year to the alcohol and other drugs treatment sector, from federal and state/territory governments, is needed to meet the minimum level of demand (200,000 people).⁵⁸

The alcohol and other drugs treatment sector is one of the last sectors not to utilise a national, evidence-informed planning framework to guide and plan public investment. We call on both federal and state/territory governments to work together in embedding a nationally consistent planning model for the Australian alcohol and other drugs treatment sector. We urge the NSW Government to play a leadership role in pursuing such a policy outcome.

One such model – the Drug and Alcohol Service Planning Model (DAPSM) – was developed between 2010 and 2013 to enable nationally consistent, evidence-based planning for alcohol and other drug services in Australia, however has not been implemented. The model was designed to estimate demand for treatment services, specify optimal care packages, and calculate the resources needed to provide services.

Implementation of the model would require leadership and engagement with the community and the non-government sector for joint planning, implementation and review.

We recommend that the NSW Government work with the Commonwealth and other state and territory governments to form and fund a working group to update DAPSM so NSW and

⁵⁶ Ritter, Alison, et al, 2014, *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, UNSW.

⁵⁷ Ritter, A, et al., 2014, *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, UNSW.

⁵⁸ Reform of the alcohol and other drugs treatment sector, Australian Government Pre-Budget Submission 2019-2020.

Australia can have a world class national planning model for the alcohol and other drugs treatment sector. A working group with representation from all jurisdictions would:

- incorporate learnings from implementation of similar planning models, eg: in Australian mental health service systems, and in the Western Australian alcohol and other drugs treatment system;
- integrate the National Quality Framework for Alcohol and Other Drug Treatment Services and the National Treatment Framework;
- plan a staged and coordinated expansion of service systems, including workforce development (which includes also the peer workforce); and
- form and fund a technical working group to update the 2013 model including a review of the epidemiology and tailoring to specific population groups and locations.

Better investment planning through implementation of the DASPM across jurisdictions will improve access to high quality services and make recruiting and retaining an effective specialist alcohol and other drug treatment workforce easier. It will also assist key primary, acute, specialist and community services organisations to coordinate and plan their service delivery and models of care.

This will mean better outcomes from alcohol and drug treatment for hundreds of thousands of Australians and their families through accessing the right kind of care, at the right place, at the right time. It would also mean that the funding allocated across NSW and Australia is based on evidence and demand, not on historical funding levels and approaches which do not meet the needs of patients, families and communities.

2. National strategy on treatment services

Another area of treatment services requiring reform is the need to address the inequitable distribution of treatment services which means that some population groups and communities, including regional and rural communities, experience particularly severe lack of access.

Further, the division of responsibilities between the Australian government, states and territories must be clarified, and coordination improved.

We call on the NSW Government to join with representatives from across the state's alcohol and other drugs treatment, health, social, carers, legal and justice sectors, and with the Commonwealth and other state and territory governments, and work together on developing a national strategy for the alcohol and other drug treatment sector that:

- advises on a comprehensive and integrated system of clinical and social services for individuals and families experiencing alcohol and drug-related problems;

- implements initiatives to address stigma and discrimination against people with alcohol and drug related problems, and alcohol and drug treatment service staff;
- promotes better coordination between different levels of government, their agencies, and communities in the development of the workforce, including a peer workforce and delivery of treatment services;
- contributes to the development of a culture of continuous improvement in NSW and Australia's alcohol and drug treatment sector and enhancing the accountability and transparency in treatment services through the provision of independent reports and advice as well as development of evidence-informed guidelines for treatment;
- ensures consumer voices are represented and that policy and service provision takes into account consumer experience and needs;
- identifies unmet needs and makes recommendations about legislation and funding to address those needs as well as to ensure there is ongoing investment in continuity of care to address relapse and long term needs of individuals and their families; and
- allows for the coordination and provision of data to high level forums such as the Ministerial Forum for Drugs and Alcohol so support for the workforce at state and territory levels is evidence-based and directed at the needs of each jurisdiction.

A focus on the above would drive substantial improvement in health and well-being by drawing on evidence to shape future policy and program responses, improving the quality and outcomes of alcohol and drug treatment, and increasing efficiency and cost effectiveness across all levels of government.

3. Treatment services and workforce

Insufficient short-term funding and poorly designed and unreliable funding systems have also undermined NSW's and Australia's alcohol and drug treatment service workforce, quality and growth.

Common features across the service system include:

- run-down and poor quality physical infrastructure;
- lack of capacity to help clients address barriers to service access, like child-care responsibilities or transport;
- lack of capacity to work holistically and in coordination with other health and social services;
- lack of capacity to invest in research translation, service improvement and evaluation;
- lack of capacity to meet the needs of culturally diverse client groups;
- lack of ongoing upskilling and education support for staff; and
- high levels of job insecurity.

We call on the NSW Government to work with the Commonwealth and other states and territories to establish and fund an alcohol and other drug treatment sector capability fund. Such a fund would provide professional advice as well as financial grants to alcohol and drug treatment organisations.

Funding would be provided for evidence-based service improvement and evaluation, effective specialist alcohol and other drug treatment workforce, and capital works to improve the physical infrastructure of services.

This capability fund would also provide financial grants to organisations to build the capacity of treatment services, to enable them to be more inclusive and responsive to the spectrum of need in the community. It would organisations improve their management and operational skills; improve their understanding of, and skills in, measuring outcomes; and enhance 'best practice' in service delivery, for example, by developing tools and resources that support personnel providing services.

The fund would enable rapid improvement in alcohol and drug treatment service quality and accessibility, including by retaining and developing a capable and effective workforce. This would mean that in NSW the service system can immediately start to generate better outcomes from alcohol and drug treatment for hundreds of thousands of individuals and their families.

Social determinants of drug use

While drug prevention and treatment have traditionally focused on changing individual behaviours, such efforts can have only limited impact when changes are not made to the social determinants of drug use. These include the social and cultural environment, the economic environment and the physical environment.

The evidence between social determinants, such as unemployment, homelessness, poverty, family breakdown and drug use is strong, and demonstrates the need for a whole of government response that is grounded on strong partnerships and integrated service approaches.

Improving links and coordination between health, education, employment, housing and other sectors will in turn expand the capacity to effectively link individuals from treatment to the support required for them to reconnect with the community.

On a daily basis, our public hospitals witness the cycles that influence the development of substance use disorder. Many of the clients and patients we treat require long-term counselling because of their complex histories of multiple episodes of trauma, often from early childhood, which have led to the cycle of unemployment, housing, social welfare dependence and poorer health outcomes.

NSW and Australia need a systematic, integrated and coordinated long-term approach to the prevention of drug problems that has at its centre a social determinants focus. For St Vincent's, such an approach aligns with our Mission which reasons that all members of society should flourish to ensure the development of that society as a whole.

ATS use and stigma

As mentioned elsewhere in this submission, stigma is a major barrier for stimulant users in seeking help and access treatment.

Developing a sustained and comprehensive stigma reduction strategy to improve community and service understanding and attitudes towards stimulant use and dependence and enable affected individuals to seek treatment and help is crucial.

One of the greatest sources of stigma associated with stimulant use is the mainstream media.

Largely, the current media representation of stimulant use promotes a climate of fear. The use of terms like 'scourge' and 'threat to society' are anti-public health and stigmatising, and may prevent people from seeking treatment. Furthermore, media representations can influence people into thinking that more people use stimulants than is the case and can contribute to normalising and therefore potentially increasing its use.

These awareness and fear-raising approaches are in any case unlikely to be effective in the absence of broader societal shifts arising in response to strategies that address the reasons for hazardous and harmful use of drugs (illicit and licit).

Governments can play an important stewardship role in addressing stigmatising media reportage.

Like the successes in media reporting of suicide, governments should broker media accords for responsible reporting of ATS use that promotes treatment seeking.

Medically supervised injecting centres (MSIC)

SVHA supports the role played by medically supervised injecting centres – including the centre at Kings Cross – to both increase referrals to, and improve access to, treatment services as well as save lives, both for opioid and methamphetamine users.

Around 20% of visits to the Sydney MSIC involve the injection of methamphetamines.⁵⁹

⁵⁹ Making the case for drug consumption rooms, The Pharmaceutical Journal, Thomas Broe, May 2016

The medically-supervised injecting model which currently exists in Sydney and in other places, such as Vancouver, are not drug treatment services. However, they are health services staffed by health professionals and their interventions include health checks and clinics, health education, counselling and allied health therapies.

These objectives have been measured for effectiveness extensively, and services have been found to:

- Cultivate long-term therapeutic relationships with injecting drug users, which make possible health interventions that would not otherwise exist.
- Reduce overdose deaths (and brain damage) by treating immediately and on site:
 - At Sydney's MSIC, staff manage an overdose a day on average with oxygen. About once a week requiring naloxone.
- Provide a gateway to treatment (and other health and welfare services) by providing a low threshold, non-judgemental service staffed by skilled professionals who provide support and referral when appropriate:
 - Significant increases in detox (around 30%) and treatment uptake independently attributable to the MSIC (Vancouver).
 - In Sydney, significant proportion of clients (40%) have never been in treatment and therapeutic relationships are built over time:
 - Between 2001-02 and 2010-11, 3,871 referrals for drug treatment were made, the vast majority for pharmacotherapy and detoxification. Around 14% of clients accepted a referral over the period.
 - The more frequently a client visited the Sydney MSIC, the more likely they were to accept a referral to a drug treatment service: 64% of frequent attenders (>98 total visits a given year) accepted a referral to drug treatment, whereas only 1% of infrequent attenders (1-2 total visits a year) accepted a referral.
- Reduce unsafe injecting practices and transmission of blood borne viruses through provision of clean injecting equipment and real-time health advice.
- Reduce discarded needles and public injecting.

The sorts of alcohol and other drug sector planning reforms recommended by SVHA earlier in this submission would benefit authorities in understanding whether one or further MSIC sites are required in NSW.

Drug/substance testing

SVHA supports the concept of holding a rigorously evaluated drug testing trial to examine its potential at reducing the harms associated with drug use, including death.

SVHA encourages the NSW Government to work together with their Commonwealth and state and territory colleagues, law enforcement and health authorities to coordinate a drug testing trial across a broad range of events and jurisdictions, including incorporating fixed site testing to complement mobile, on-site testing (eg: at music and dance festivals) where drug taking is likely to occur.

SVHA support for a trial does not indicate an endorsement of drug use or that we believe drug taking is a safe activity. We regret that our culture is one in which people use drugs, including alcohol to excess. Drug use can cause serious harm to individuals, families, and communities. Our hospitals and clinicians see first-hand the damage that comes with drug taking. Our addiction medicine facilities are unable to meet the demand for help.

SVHA also recognises there are strongly held concerns around drug testing, including around the possible limitations of on-site testing and the concerns that drug testing may wrongly lend the appearance of safety.

However, we believe a trial will contribute to the development of a more solid evidence-base concerning which interventions are the most successful in saving lives, challenging risky behaviours, and minimising damage, particularly in an Australian context.

Our motive is reducing fatalities and other negative impacts that stem from dangerous drug use.

Any drug testing trial must clearly demonstrate a significant reduction in injuries and fatalities associated with dangerous drug use and of drug taking behaviour, including at music and dance festivals.

While it is clear that drug testing alone cannot prevent all overdoses and deaths, experience from overseas suggests that it could have an important role in reducing overdoses and deaths.

A recent evaluation of the UK's first pill testing trial – held over four days at a music festival in the UK in 2016 – found one-in-five substances tested were not what people expected, and among people mis-sold substances, two-thirds chose to hand over further substances to be destroyed.⁶⁰

⁶⁰ Drug safety testing, disposals and dealing in an English field: Exploring the operational and behavioural outcomes of the UK's first onsite 'drug checking' service, International Journal of Drug Policy, December 2018.

Further, there was a reported 95% reduction in drug-related hospital admissions from the festival compared with the previous year.

In research into pill testing in Austria, 50% of those who had their drugs tested said the results affected their consumption choices. Two-thirds said they wouldn't consume the drug and would warn friends in cases of negative results.⁶¹

A total of 128 people, ranging in age from 17 to over 40, took part in the pill testing trial at Canberra's Groovin' the Moo music festival in April 2018, resulting in a total of 85 substances being detected, including ecstasy, cocaine and ketamine, but also toothpaste, arnica (a muscle rub), and hammerite (a spray paint used on metal).⁶²

The pill testing also discovered two highly toxic chemicals, including the normally lethal N-Ethylpentylone (ephylone), which can cause circulation problems, lethal heart palpitations and hallucinations, and is responsible for a number of mass overdoses around the world.

New drugs, never before identified as circulating in the ACT, were also detected among those sampled.

While five people used the bin provided by the medical tent to get rid of their drugs, 42 per cent of those who brought drugs for testing reported that their drug consumption behaviour would change as a result of the testing.⁶³

Media reports from the second ACT trial – also conducted at Groovin' the Moo in April 2019 – indicate it too was a success with seven substances containing N-Ethylpentylone identified along with MDMA, cocaine, ketamine and methamphetamine during the 171-sample trial.⁶⁴

In terms of other related evidence, a recent US-Australian study found that 54 per cent of ecstasy users were less likely to use the drug again if they learned it contained 'bath salts' (synthetic cathinones) or methamphetamine.⁶⁵

Any drug testing trial should provide highly trained healthcare workers with the opportunity to engage drug testing participants with information about the risks and harms associated with drug use, including offering a pathway to seeking treatment and further support if required. It is not often health workers are given an opportunity to intervene immediately before people choose to take these drugs.

⁶¹ On-site pill testing interventions in the European Union, European Monitoring Centre for Drugs and Drug Addiction, July 2001.

⁶² Report on the ACT GTM Pill Testing Pilot: a Harm Reduction Service Prepared by the Safety Testing Advisory Service At Festivals and Events (STA-SAFE) Consortium June, 2018

⁶³ Report on the ACT GTM Pill Testing Pilot: a Harm Reduction Service Prepared by the Safety Testing Advisory Service At Festivals and Events (STA-SAFE) Consortium June, 2018

⁶⁴ <https://www.sbs.com.au/news/australia-s-second-pill-testing-trial-in-canberra-overwhelmingly-successful>

⁶⁵ Prevalence of reagent test-kit use and perceptions of purity among ecstasy users in an electronic dance music scene in New York City, Drug and Alcohol Review, December 2018.

Data collection attached to the trial should also allow governments, health authorities, and law enforcement with the opportunity to monitor and detect new and emerging harmful substances.

We believe that a comprehensive trial also requires the inclusion of fixed sites for drug testing. A network of fixed sites – as is used in the Netherlands’ illicit drug surveillance model – complements off-site testing by offering additional data for surveillance, drug trend monitoring, the detection of new and emerging drugs and additional opportunity for more extensive counselling.

We acknowledge that drug testing – were a trial to confirm its effectiveness – isn’t a silver bullet for ending drug-related harms and fatalities. Any drug testing – if found to be useful – needs to be considered as part of a multi-faceted approach to the issue, including efforts at prevention, adequately funded health and social services (e.g.: early intervention, treatment services) and law enforcement.

But ultimately, if people are determined to take drugs, then we need to understand – with evidence that stands up to scrutiny and obtained in an Australian environment – whether drug testing can help keep them safe, or indeed save their lives.

3.4 Data, Research and Funding Issues Paper 3

Traditionally, one of the challenges facing Australia’s ability to address stimulant use has been a lack of research into more effective treatments and the need to provide better training for the healthcare professionals responding to the problem.

This was an issue identified by the National Ice Taskforce and in response led to the establishment of the National Centre for Clinical Research on Emerging Drugs (NCCRED) as part of the Commonwealth’s National Ice Action Strategy.

NCCRED’s purpose is to generate new evidence-based knowledge that will lead to improved treatment and health outcomes. It aims to better ensure the translation of evidence-based research outcomes into clinical practice, thereby responding to drug-related health problems as they emerge.

A primary aim of NCCRED is to develop, implement and disseminate innovative and effective evidence-based treatment interventions that can be applied to the use of methamphetamines and new and emerging substances. Crucial to achieving this aim, and a defined activity for the Centre, is the establishment and support of clinical trials.

To determine the priority areas for clinical research and the essential questions that stakeholders (e.g.: consumers, concerned others, clinicians, researchers, experts, institutions/organisations, and other interested community members) wish to see answered by clinical research, NCCRED has conducted a research priority setting study; results are soon to be published.

The results of the larger study will be used to inform NCCRED on the research priorities that its sponsored clinical trials and funding programs should aim to address. Secondary outcomes will compare and contrast the priorities identified by various stakeholder groups. Results will be published to ensure transparency of the methods.

When published, given the study's status as the only peer-reviewed alcohol and other drug sector health research priority setting exercise published in Australia, the results may inform other funding bodies, policymakers, and clinical researchers.

NCCRED has also established a seed funding research program to develop evidence-based treatments and treatment models in response to prevalent, persistent and harmful emerging substances or methamphetamines.

Grant recipients will contribute to the implementation of new and innovative treatment interventions. The funding will provide financial support as a seed-funding grant to establish investigator-initiated clinical trials / treatment research. The initial funding round specifically targets those projects investigating treatment options for methamphetamine or emerging drugs of concern dependence / use disorder; with subsequent funding rounds broadening the scope to include any new or emerging drug of concern.

Finally, NCCRED has also established the Methamphetamine and Emerging Drugs Clinical Research Network Working Group to mobilise a national research network and contribute to the evolving research strategy and capacity development activities of NCCRED.

Elsewhere, outside of NCCRED's work, there is a need to standardise national measures in order to make clear and qualified statements about drug use and harms.

Currently, there is a multitude of monitoring systems and parameters that operate within Australia, all of which are rich sources of information, but equally, make it hard to definitively compare data or draw conclusions.

This challenge is particularly experienced in hospital Emergency Departments because of the wide variety of diagnoses and complexity of acute presentations.

For example, some ED presentations will receive a diagnosis of Poisoning whereas others receive Psychotic Episode, Acute Behavioural Disturbance, Delirium, and Suicidal Intent/Ideation. Furthermore, some patients may not admit to using drugs or are unable to state usage (e.g.: unconscious, deceased).

Currently there is no national mandatory requirement to routinely collect Emergency Department data on stimulants and other illicit substances that have contributed to harms, injuries and assaults that present and/or are admitted and managed in the acute and sub-acute health care settings. This means that attempts to quantify such presentations through existing systems have to date provided gross underestimates.

Building and improving the evidence base by introducing mandatory national measures that can be shared, is an important strategy to not only inform policy direction but also highlight research priorities.

SVHA recommends a systematic and nationally standardised approach to data collection measures to enable the collection, dissemination and sharing of information that is required to guide research, policy, evidence of best practice and current trends in the area of stimulant use.

Such an approach would ensure that priority areas for research are identified and coordinated; that the identification of emerging issues for research is facilitated; testing and validation of new interventions is encouraged; and, there is guidance on the best way to disseminate findings and assist the translation of those findings into practical policies and programs.

3.5 Appendix

3.5.1 St Vincent's Alcohol and Drug Services Summary

The ADS' **Contact Centre** consists of a unique team of professionals who provide 24/7 information and support on alcohol and other drugs through a variety of call lines. The Centre delivers the NSW Health sponsored Alcohol and Drug Information Service (ADIS) to provide telephone (and soon to be web-based) education, information, referral support and crisis counselling. Callers receive confidential and non-judgemental support on any issues related to substance use and treatment options. The call service can also be accessed by family members, friends or other professionals.

The **Drug and Alcohol Specialist Advisory Service (DASAS)** is a similar support service designed specifically for health professionals. Callers are assisted with clinical diagnoses, treatment and client management for people with alcohol or other drug problems. The 24/7 service provides access to specialist advice from medical specialists, and assists with support to clinicians who may be located in regional, rural or other areas.

Other call lines operated by the centre include the Stimulant Treatment Line (STL), Opioid Treatment Line (OTL), Cannabis Caution Line, ACT Quitline and 1300DRIVER.

The **Gorman Inpatient Unit** is one of the few dedicated inpatient substance use disorder centres in the state. The acute inpatient short-stay unit offers specialist alcohol and other drug withdrawal management, stabilisation and treatment for complex to severe substance use disorders.

The newly refurbished unit opened in January 2017, and currently accommodates 13 beds for patients with a wide variety of substance dependencies. The unit is open to people of all genders over the age of 18, with many travelling from across the state to access services.

Gorman Unit has a unique ability to treat clients with multiple co-morbidities, incorporating collaborative care models with services such as mental health and homelessness health. The unit also employs a dedicated Aboriginal Health Worker and Consumer Participation Worker to support individual client needs.

The **Hospital Consultation Liaison Service** is a specialist, nursing and medical team that provides advice regarding the management of drug and alcohol related issues for inpatients (including ED), as well as advancing the capacity of generalist health providers to address drug and alcohol issues in their routine clinical work.

The principal objective of the ADS Consultation Liaison Team is to enhance the safety, clinical outcomes, quality and efficiency of services for patients with substance use disorders in hospital.

Rankin Court comprises the specialised community facing Opioid Treatment Program (OTP) to provide methadone and buprenorphine treatment for people experiencing opioid dependence.

The service encompasses a daily supervised administration dispensary, and offers comprehensive assessment, medication management, care coordination, health information provision and education using a harm minimisation approach.

Clients of the service are able to access counselling, crisis support interventions and health promotion initiatives. Support is also provided for ongoing referral, consultation and liaison with GPs, other agencies and support services. Clients are also assisted in their transition to community care including community prescribers and pharmacy dispensaries.

Service programs include the Hepatitis C Clinic, Dental Clinic and needle-syringe program. The service has also recently introduced an Outreach Clinic at Matthew Talbot Hostel. Consumer Engagement and Hepatitis C Peer Support workers are available to help inform and support clients with their individual needs.

The ADS' **Outpatient Service** consists of the Gorman Unit Outpatient Service, Burton Street Centre Youth Service, and Gambling Treatment Program.

The Gorman Unit Multidisciplinary outpatient service is based at SVHS. It provides holistic, short-stay care (3-5 days) to people seeking alcohol and other drug treatment. The service is available for adult patients who are 18 and over. Treatment is available for homeless people in inner city Sydney, as well as people accessing treatment for the first time. Aboriginal and Torres Strait Islander people are encouraged to access the service, and provided with priority care. Treatment is holistic, patient-centred and individualised, with a focus on the patient playing a key role in the treatment planning

The Burton Street Centre is a free confidential counselling service for young people (aged 16 to 25) who use methamphetamine, cocaine, ecstasy and other drugs. The service also sees family members and significant others in the young person's life.

The government-funded **Gambling Treatment Program** is a corresponding specialist outpatient service which offers Cognitive Behavioural Therapy (CBT) and specialist treatment for problem gambling. The state-wide referral service offers individual client sessions and follow up from dedicated Clinical Psychologists.

Stimulant services are provided by drop in, or appointment for those aged 16 or older who use stimulants such as methamphetamine (ice), cocaine and ecstasy. In addition to outpatient counselling, the service also runs a strength based interpersonal therapy group called Link Group, and the health and wellbeing check-up clinic, S-Check. An Aboriginal Health Worker is also available to support clients to the service.

In addition to the above mentioned service areas, the ADS also comprises a number of ongoing projects and programs to enhance and support service delivery. This includes ongoing initiatives and collaboration with the Central and Eastern Sydney Primary Health

Network, Sydney Local Health District and the South Eastern Sydney Local Health District on the GP Liaison in Alcohol and Drug (GLAD) Project and Health Pathways Project. The ADS also participates in the NSW Health sponsored Assertive Community Management (ACM) Program, a specialist outreach service to provide intensive, time-limited case management, assertive outreach and specialist support for complex clients who have difficulty engaging in drug and alcohol treatment.

St Vincent's Hospital's ADS is guided by the St Vincent's Health Australia and Darlinghurst Campus strategic priorities.

- Within SVHA's 10 year strategy, enVision2025, people with drug and alcohol addiction are recognised as a priority population group to enable the organisation's overarching mission and achieve its commitment to disadvantaged populations.

On St Vincent's Sydney's Darlinghurst campus, both the Clinical Services Strategy and Clinical Services Plan (CSP) were released in 2017 to guide initiatives over the next 10 years. Within the strategy, the ADS is recognised as a pre-eminent clinical service area for future establishment of Centre of Excellence.

Other relevant services and partnerships

St Vincent's Sydney's ED and broader hospital provide general medical care to people experiencing acute and severe mental health or physical health complications related to ATS use. For example, SVHS is part-way through the construction of a dedicated specialist Psychiatric Alcohol and Non-Prescription Drug Assessment (PANDA) unit within its ED. The PANDA unit will provide short-stay and specialised treatment for this patient cohort and is scheduled for completion in 2020 alongside an expanded Psychiatric Emergency Care Clinic (PECC).

SVHS is also a consortium partner in the new National Centre for Clinical Research on Emerging Drugs of Concern (NCCRED), which was established by the Commonwealth Government in 2018 as part of its response to the recommendations of the National Ice Taskforce. NCCRED supports research into new treatment and care for drug dependence and aims to build research capacity and improve clinical response in the alcohol and other drug sector.

Dr Nadine Ezard is the Clinical Director of SVHS' ADS and is Director of NCCRED, and a conjoint Professor in the UNSW Faculty of Medicine. She has a particular interest in methamphetamine treatment research: current research projects include the NHMRC-funded trial of lisdexamfetamine for the treatment of methamphetamine dependence, and the early intervention S-Check app.

3.5.2 Our experience - St Vincent's Hospital Sydney and substance use

High rates of substance use and related offences are experienced within the SVH catchment. Across all areas, alcohol attributable hospitalisation rates are significantly higher than the state average. Between 2015-17, the highest rate of alcohol attributable hospitalisations were from Waverly LGA, at 898.3 per 100,000 population. This is significantly higher than the state average of 610.3 per 100,000 population. Woollahra has the second highest rate of 853.5 per 100,000 population. Rates within both areas have continued to increase since 2001-03. In the Sydney City LGA, rates have varied since 2001, however a more recent decline has been noted between 2009-11 and 2015-17.⁶⁶

The SVHS catchment also experiences some of the highest number of drug related offences in greater Sydney and across the state. Within the Sydney LGA, recent reports on drug related offences have indicated a rate of 3286.6 per 100,000 population. This is more than five times higher than the NSW rate of 608.8 per 100,000 population.⁶⁷ Similar reports indicate high numbers of drug related offences for drug importation concentrated in the area.

Local factors such as pockets of socio-economic disadvantage and high numbers of people experiencing homelessness may be important contributors to a higher prevalence of alcohol and substance use disorders. Prior evidence suggests homelessness is positively associated with higher rates of alcohol and other drug dependency, with some estimates indicating up to 40 per cent of this group experiences alcohol dependence⁶⁸.

LGBTQI people have also been found to be significantly more likely to use alcohol and other drugs. Previous surveys suggest this group may be up to six times more likely to be drug users.⁶⁹ A large LGBTQI community presence may be associated with an increased prevalence of drug use.

In 2016, an Alcohol and Other Drugs needs assessment was conducted by Central and Eastern Sydney Primary Health Network (CESPHN).⁷⁰ The assessment highlighted a number of issues related to access and availability of appropriate services in the local catchment.

⁶⁶ HealthStats NSW (2018). Alcohol attributable hospitalisations. Available at: http://www.healthstats.nsw.gov.au/Indicator/beh_alcafhos/beh_alcafhos

⁶⁷ NSW Bureau of Crime Statistics and Research (2019) Incidents of Drug Offences from October 2017 to September 2018. Available at: <http://crimetool.bocsar.nsw.gov.au/bocsar/>

⁶⁸ Alcohol and Drug Foundation (2018). Alcohol and other drug use, and homelessness. Available at: <https://adf.org.au/insights/aod-use-and-homelessness/>

⁶⁹ AIHW (2017). National Drug Strategy Household Survey 2016: Detailed Findings

⁷⁰ CESPHN (2016). Alcohol and Other Drugs Needs Assessment

Overall, there were found to be very low numbers of pharmacies providing opioid agonist treatment across the region. Within the Waverley and Woollahra suburbs, only two pharmacies were found to provide opiate substitution treatment.

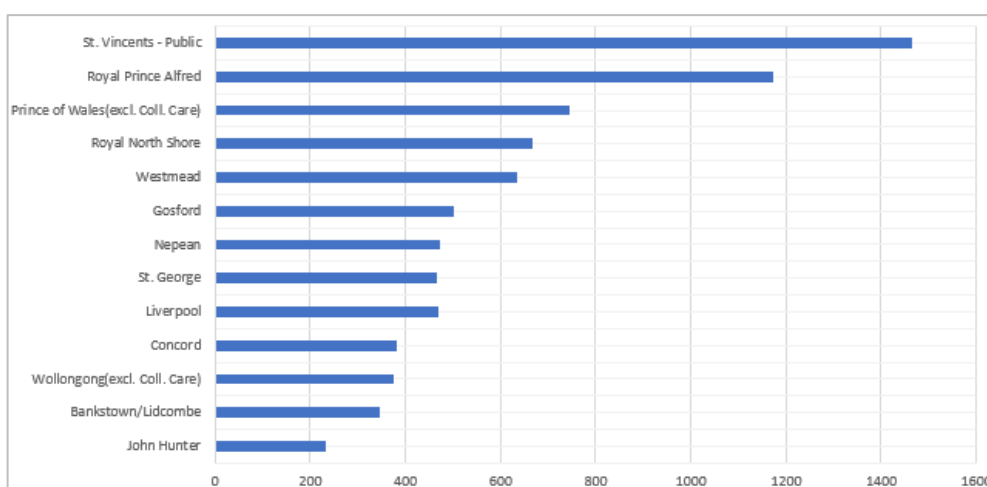
Furthermore, low rates of GPs/Specialists engaged in referrals, provision of co-morbidity services, counselling, information, education and case management services for patients with alcohol and other drug needs was noted in the local area. A lack of appropriate withdrawal and rehabilitation services was also identified for specific cohorts.

Appendix xx provides further information and data regarding substance use and presentations

3.5.3 Emergency Department Activity

As an A1 principal referral hospital and major trauma centre for Sydney CBD, SVHS experiences a significant number of alcohol and drug related presentations to its ED. Over the past five years, SVHS has consistency experienced the highest total number of alcohol, drug abuse and drug induced mental disorder related ED presentations in NSW compared with other peer group (A1) hospitals. Comparative figures for FY2017/18 are displayed in Figure 1.

Figure 1. A1 Principal Referral Hospital ED Presentations for Alcohol and Drug Primary Diagnoses FY 2017/18



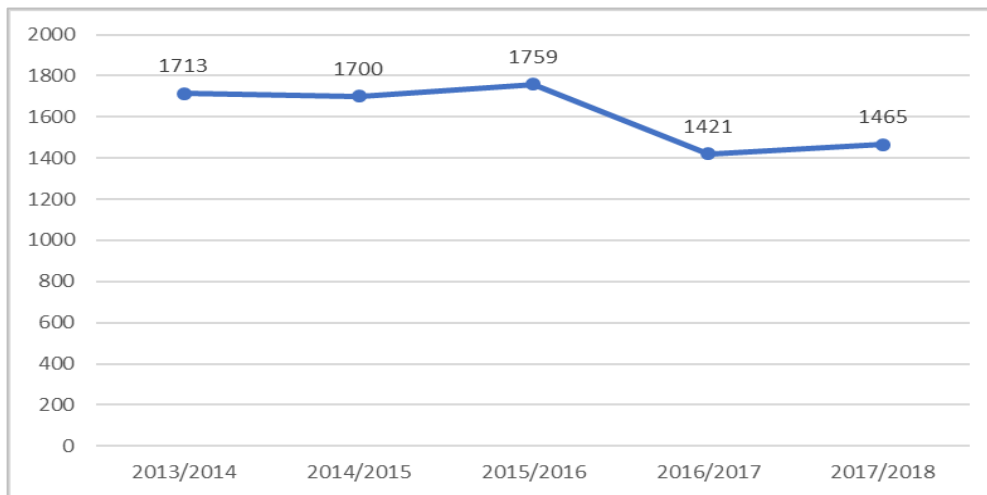
Source: NSW Health Emergency Department Activity Analysis Tool V18.0

In addition to high volumes, the proportion of alcohol and drug attributed ED presentations at SVH is approximately three times the state average.

Between FY2013/14 and 2017/18, the total number of presentations for a primary diagnosis of Alcohol/drug abuse and alcohol/drug induced mental disorders has decreased. However, there has been a slight increase in presentations in the last year (Figure 2).

Comparatively, the total number of ED presentations at SVHS has significantly increased during this time period (Figure 3). Contributing factors to the decrease may include the closure of Gorman House “social detox” in 2016 and reopened as a medical unit in January 2017.

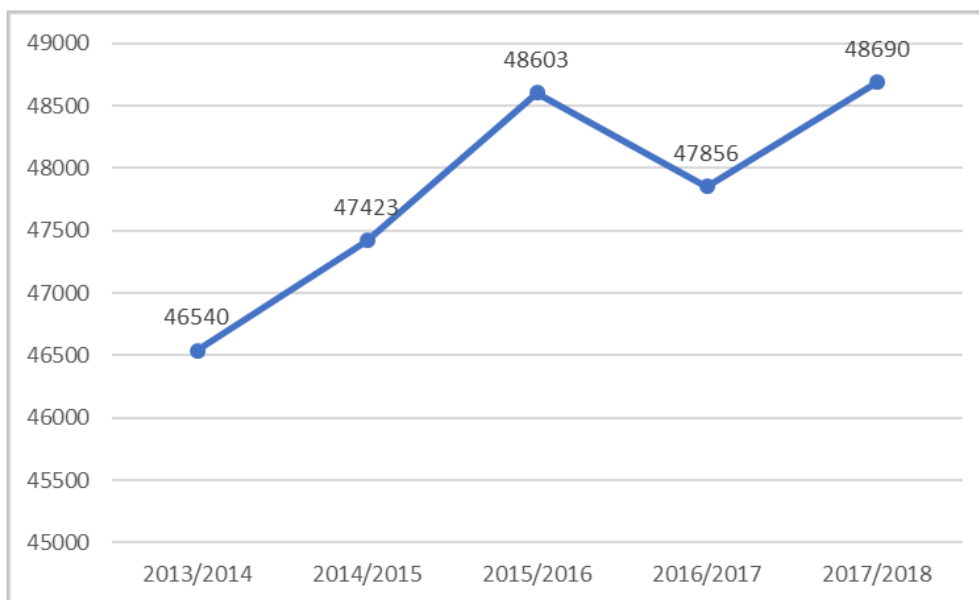
Figure 2. SVH ED Presentations for Alcohol and Drug Primary Diagnoses FY2013/14 - 17/18



Health EDAA Emergency Department Activity Analysis Tool V18.0

Source: NSW

Figure 3. SVH Total ED Presentations FY2013/14 - 17/18



Source: NSW Health EDAA Emergency Department Activity Analysis Tool V18.0

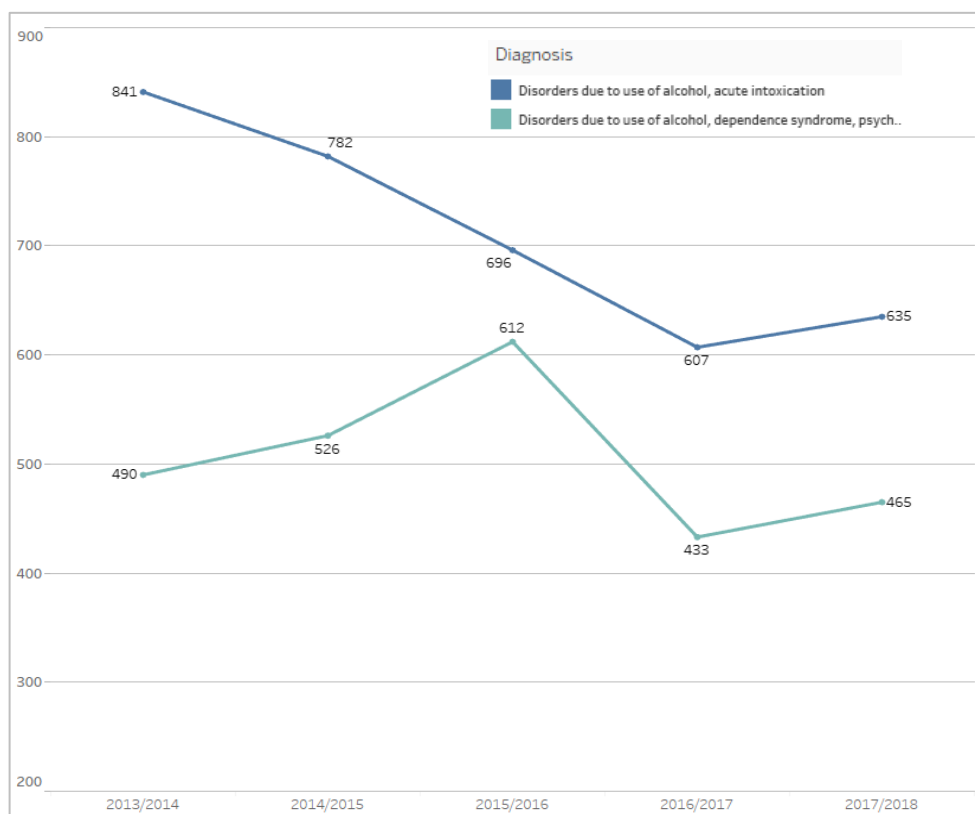
On average, in NSW there has been a decline in presentations with a primary diagnosis of Alcohol/drug abuse and alcohol/drug induced mental disorders from 2015/16.

During the FY2017/18 period, seasonal fluctuations were noted in monthly presentations, with the largest number of presentations occurring in December and January.

Daily presentations range from one to 18 presentations a day, with the highest number of presentations coinciding with Sydney Mardi Gras Festival in early March. On average, there are four presentations on any given day.

From these presentations, the large majority of episodes are associated with alcohol consumption. In FY2017/18, 75 per cent of episodes (n=1,100) were related to alcohol. From these, 58 per cent (n=635) were episodes of acute intoxication. Interestingly, the number of episodes attributed to acute intoxication has decreased significantly over the past five years (Figure 4) coinciding with the introduction of a suite of local liquor control measures (known colloquially as the Kings Cross “lockout laws”) in Feb 2014.

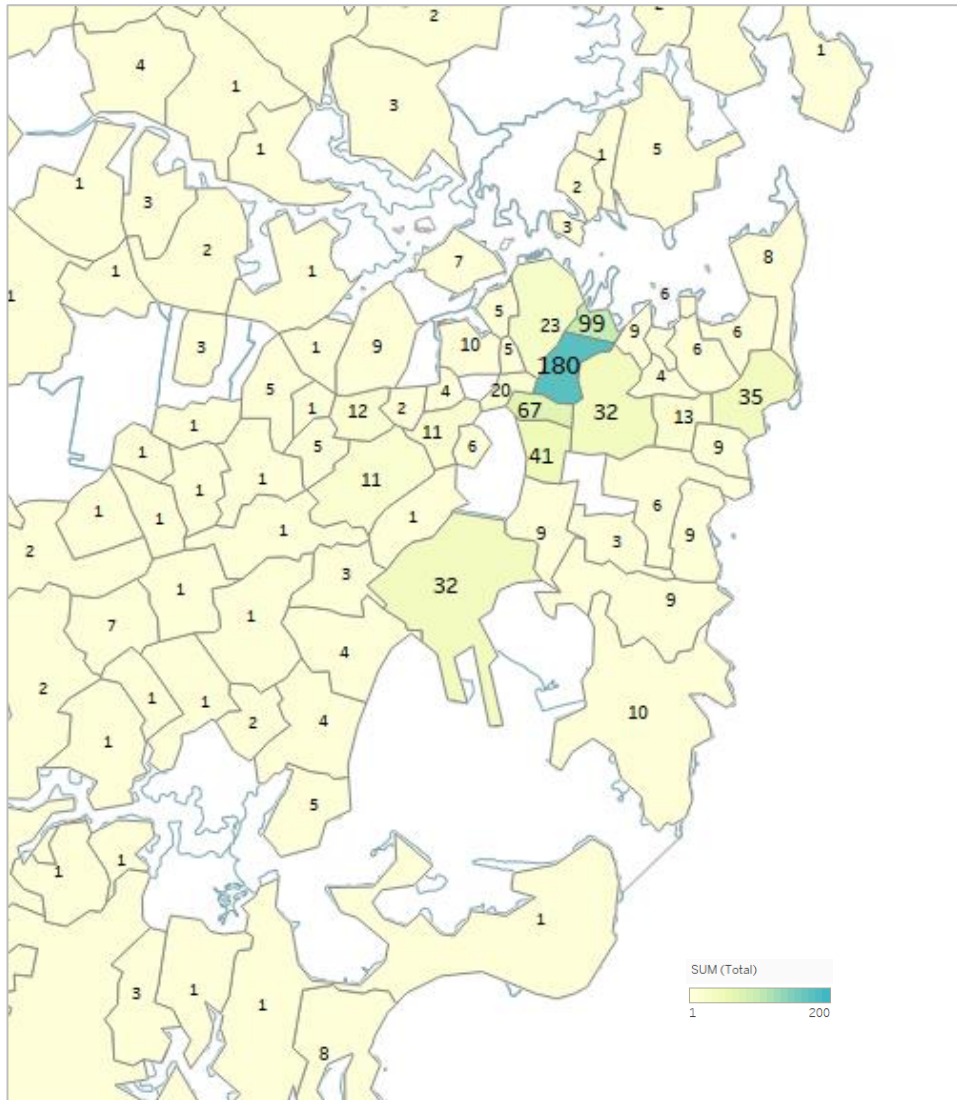
Figure 4. Alcohol Related ED Presentations FY2013/14 - 17/18



Source: NSW Health EDAA Emergency Department Activity Analysis Tool V18.0

From episodes with a known postcode, there appears to be a large spread of presentations from across metropolitan Sydney, with the largest number of presentations coming from the Darlinghurst postcode at 16 per cent (n=180) (Figure 5).

Figure 5. SVHS ED Presentations for Alcohol and Drug Primary Diagnoses by Postcode 2017/18



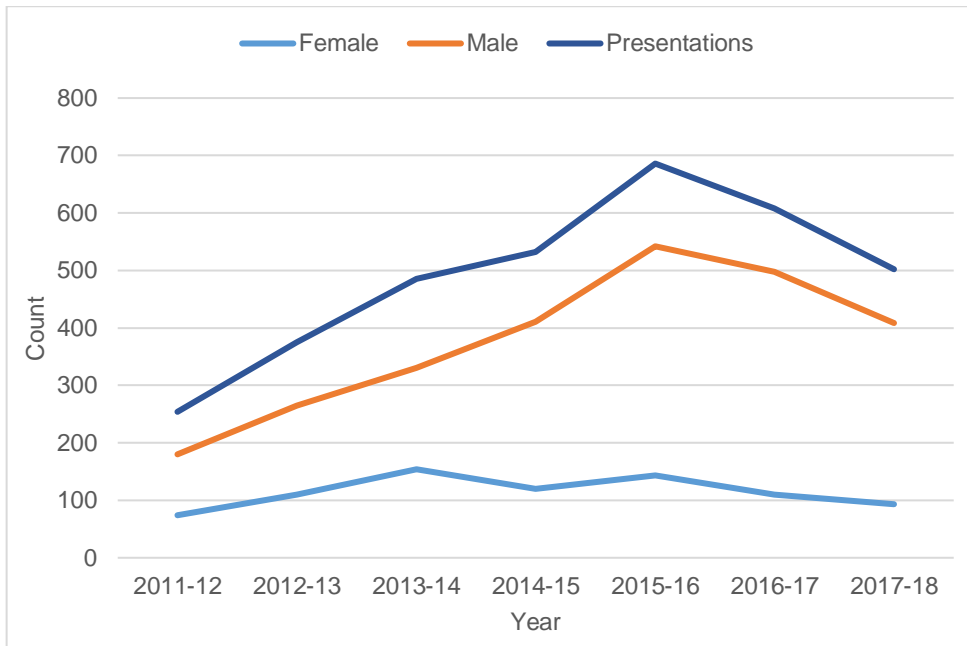
During FY2017/18, 62 per cent of episodes arrived by ambulance, however the total number of ambulance arrivals attributed to alcohol and drug use has decreased from 2013/14.

Triage category 4 and 5 episodes have also decreased in recent years. The large majority of patients are not admitted, accounting for 79 per cent of episodes. However, the number of admitted patients for this group has more than doubled in the past five years.

Approximately 65 per cent of presentations are from patients between the ages of 16 to 44 years, and 30 per cent between 45 to 64 years. There has been a notable decline in presentations from those aged 15 to 19 years from 122 in 2013/14 to 71 in 2017/18.

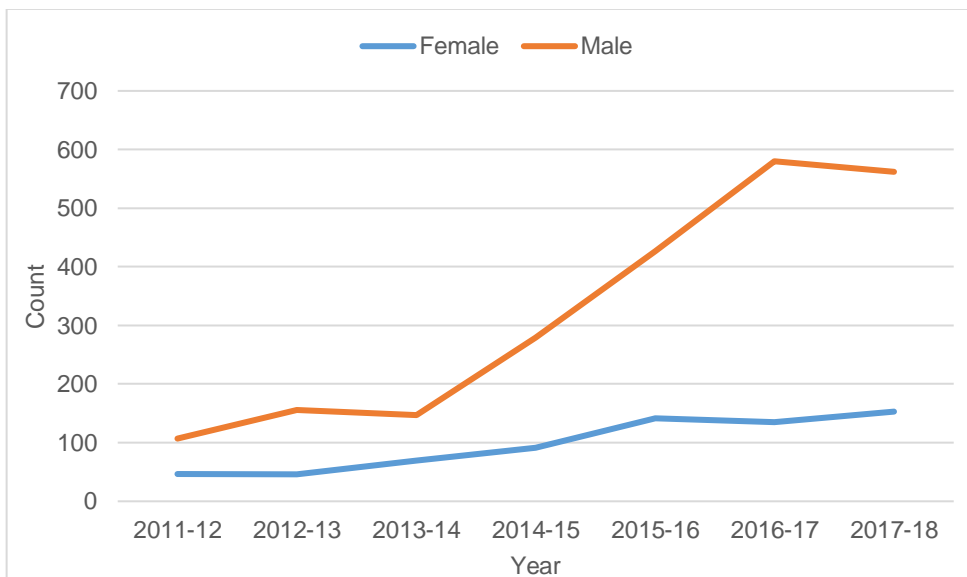
Methamphetamine-related presentations to SVHS’s ED peaked in 2015-16 but have declined in the past two years (Figure 6).

Figure 6. SVHS Methamphetamine-related presentations to Emergency Department



Source: NSW Ministry of Health

Figure 7 - methamphetamine-related hospitalisations increased until 2016-17 – significantly among males – before tapering off in 2018. SVHS methamphetamine-related hospitalisations 2011 – 2018

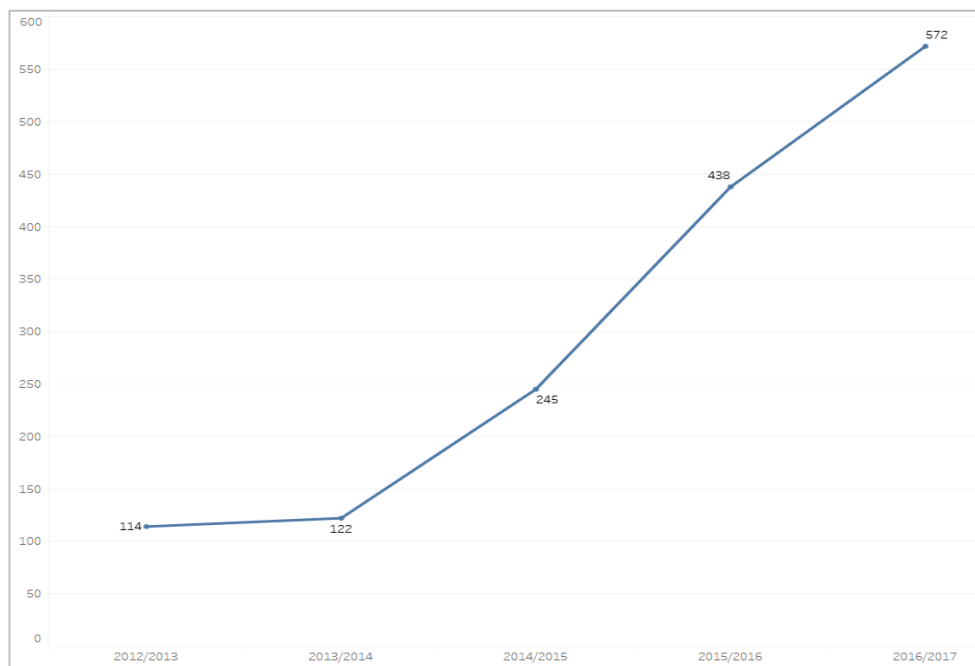


Source: NSW Ministry of Health

3.5.3 Inpatient Activity

Over the past five years, **inpatient activity has greatly increased** (Figure 8), accelerated by the refurbishment and re-opening of the Gorman Inpatient Unit in January 2017.

Figure 8. Alcohol and Drug Attributed Admissions FY2012/13 – 2016/17



Source: NSW Health FlowInfo 17 Episodes for ESRGv50 812 Drug and Alcohol Dependence and Withdrawal (Excluding ED Only)

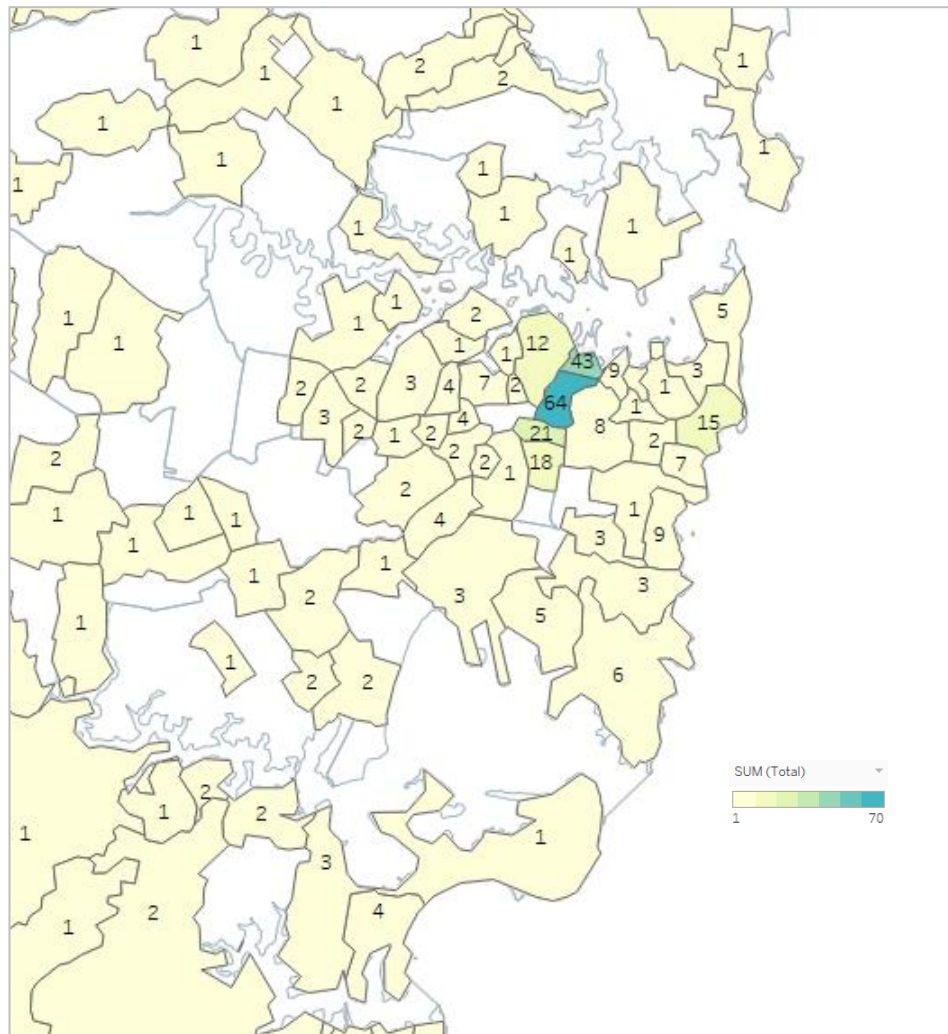
Over the course of six months following the Gorman Unit re-opening, inpatient activity more than doubled from an average of 29 admissions per month to 66 admissions per month on average. Between January 2017 and September 2018, there was an average of 76 monthly admissions, or 3 admissions per day. This ranged between 1 to 9 daily admissions.

The average length of stay and average bed days have also significantly increased following the re-opening. Between January and June 2017, average bed days increased from 2.98 to 4.39.

Since September 2017, Gorman Unit bed closures have resulted in a slight decrease in total numbers of admissions, however bed occupancy has remained high.

In FY2016/17, the post code of residence was not stated for nearly a quarter of episodes. However similar to ED presentations, the largest number of admissions is from residents of the local area. 11 per cent of episodes (n=64) were found to reside within the Darlinghurst postcode (Figure 9).

Figure 9. Alcohol and Drug Attributed Admissions by Postcode FY2017/18



From admissions to the Gorman Unit between January 2017 and September 2018, 51 per cent of admissions (n=819) were self-referred, 36 per cent (n=573) were from ED and 11 per cent (n=180) were from other agencies. The number of ED referrals has remained relatively consistent during this period, while referrals from other agencies has declined.

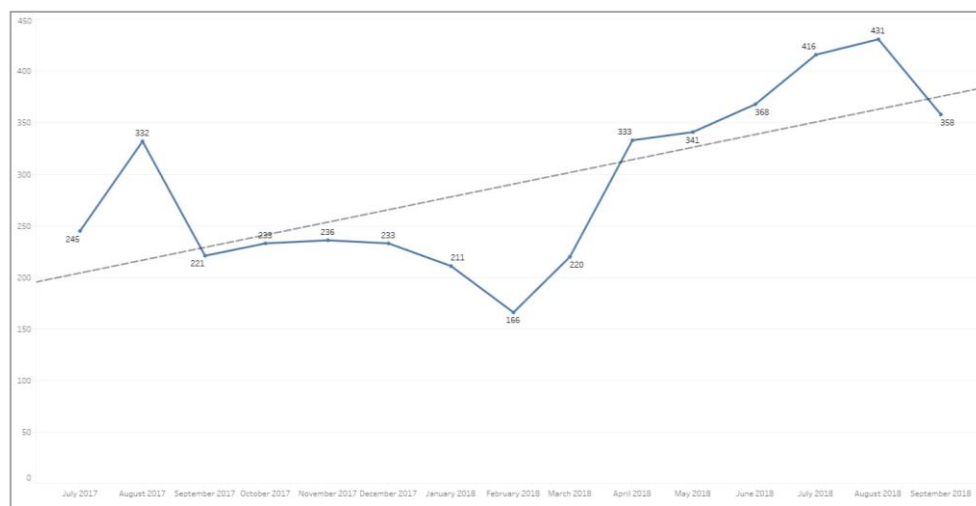
A large proportion of admissions to Gorman Unit are attributable to readmissions. Between January 2017 and September 2018, 28 per cent (n=451) of the total admissions were a readmission from within the same time period. From readmission episodes, 66 per cent (n=196) of individuals had two admissions and 23 per cent (n=68) had three admissions, however the highest number of admissions for one individual was 8 separate admissions during this period.

Across Gorman Unit admissions between January 2017 and September 2018, 92 per cent of patients (n=1,058) were between the ages of 20 and 59, with the highest number of patients (n=354) being between 40-49 years of age.

Nearly 72 per cent (n=819) of patients were male. During FY2016/17, 13 per cent of episodes (n=72) were for individuals who identified as Aboriginal and/or Torres Strait Islander.

Hospital Consultation Liaison activity has also grown over the past year. The total number of episodes has increased from 245 in July 2017, to 358 in Sept 2018 (Figure 10). The number of weekly and daily episodes appears to be highly variable, with an average of 15 episodes a day during this period.

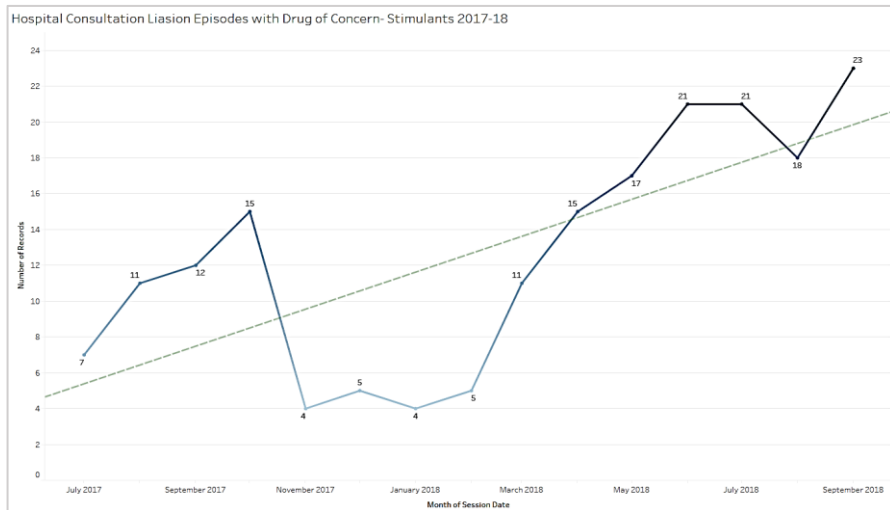
Figure 10. Consult Liaison Activity July 2017 – Sept 2018



Source: CHIME

From first consult episodes, the most common substance of concern was alcohol at 47 per cent (n=786) closely followed by opioids at 38 per cent (n=644). Consults related to stimulants accounted of six per cent of episodes (n=105). Although opioid related activity has remained relatively constant, alcohol related activity has significantly increased from 32 episodes in July 2017 to 129 in Sept 2018.

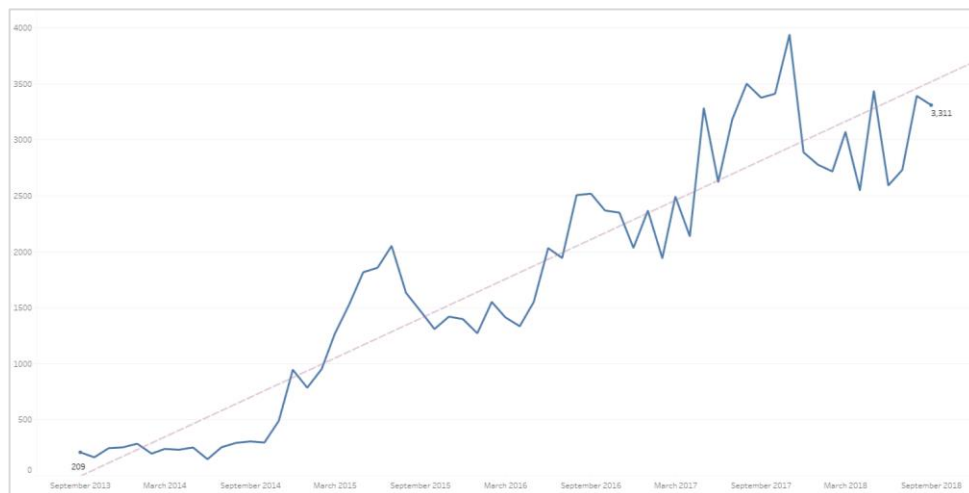
However, over the same period, the number of times the service was consulted for patients with issues related to stimulants increased (Figure 11).



3.5.4 Outpatient Activity

Outpatient episodes have grown significantly over the past five years. Between September 2013 and September 2018, the total number of monthly episodes has increased dramatically (Figure 12).

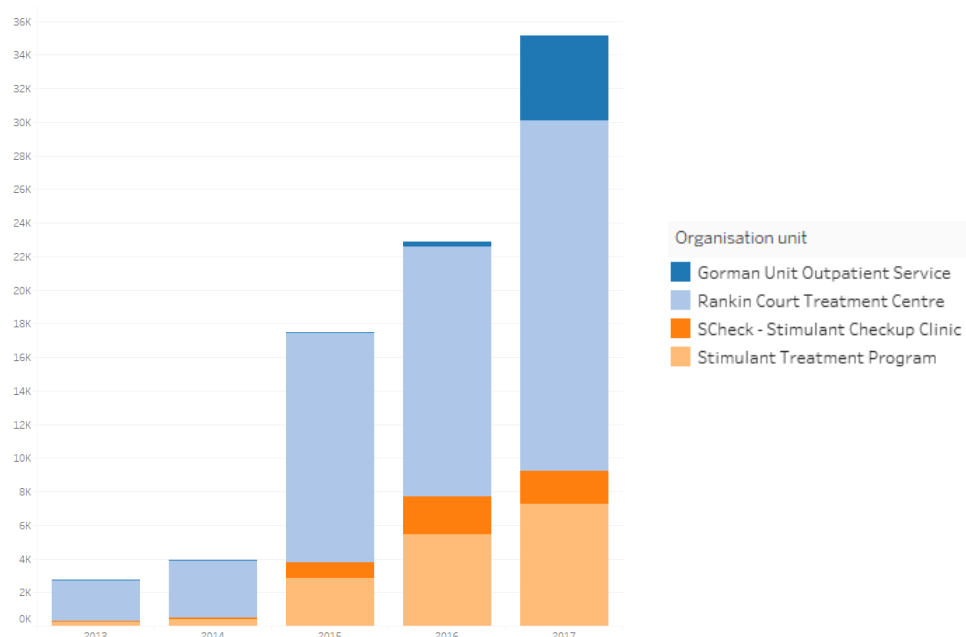
Figure 12. Total Monthly Outpatient Episodes 2013-2018



Source: CHIME

This activity increase has been driven by the introduction of new services, including the Gorman Unit Outpatient Service and ACM Program. However, the total number of Stimulant Treatment Program and Rankin Court episodes has also increased significantly during this time (Figure 13). Future growth is still anticipated with the recent introduction of the Burton Street Youth Service.

Figure 13. Total Yearly Outpatient Episodes 2013-2017



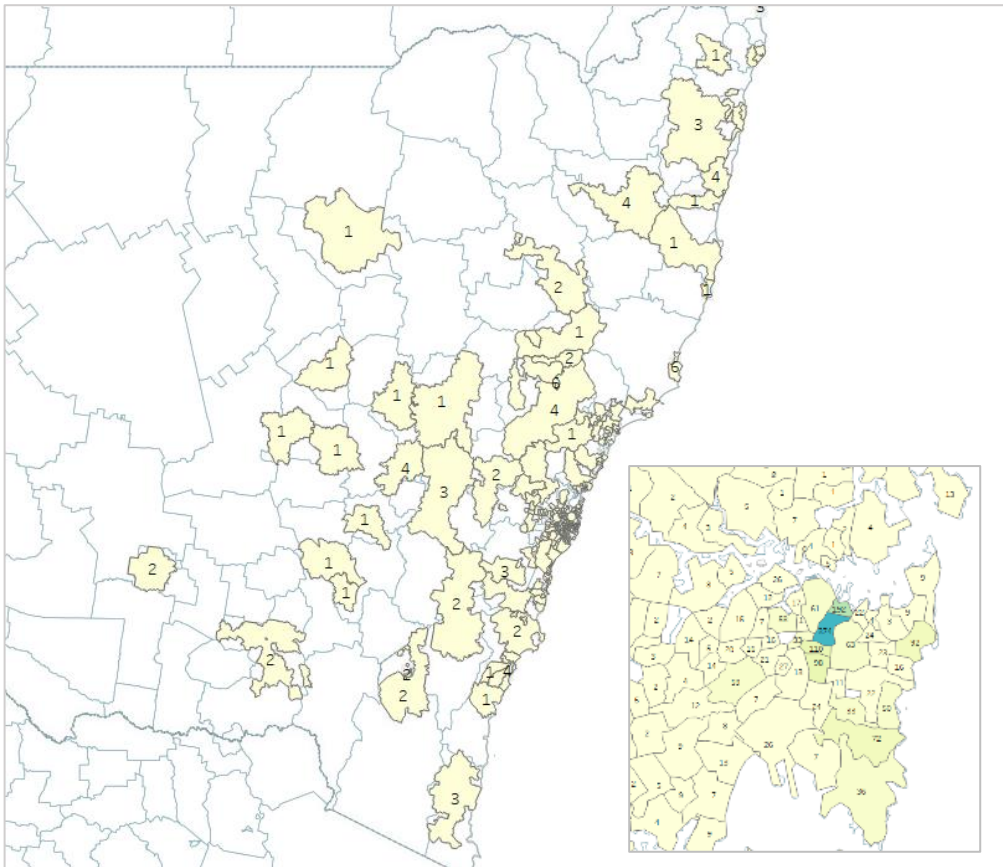
Over the past five years, the proportion of direct and indirect client activity has also changed, with the proportion of indirect activity increasing to exceed direct client activity in August 2017. Both Gorman Unit Outpatient and ACM Programs have a higher proportion of indirect client activity (i.e.: case planning and review, and clinician-end telephone consultation), likely contributing to this shift.

The number of outpatient referrals has also increased over the past five years. Monthly referral rates have increased from 178 in January 2013 to 296 in January 2018. Between September 2017 and August 2018, there were between 209 and 296 referrals per month, with an average monthly referral rate of 252.

Across all services, the majority of referrals are to the Gorman Unit Outpatient Service, receiving 76 per cent (n=2,304) of all referrals between September 2017 and August 2018. During this same period, 92 per cent of referrals (n=2,803) were self-referred from the client, five per cent (n=146) were from another health service provider and two per cent (n=62) from another drug and alcohol treatment agency.

From referrals with a known post code (n=2,705), the largest number were from Darlinghurst at 14 per cent (n=374). Multiple referrals were received from beyond the metropolitan and Greater Sydney area (Figure 14).

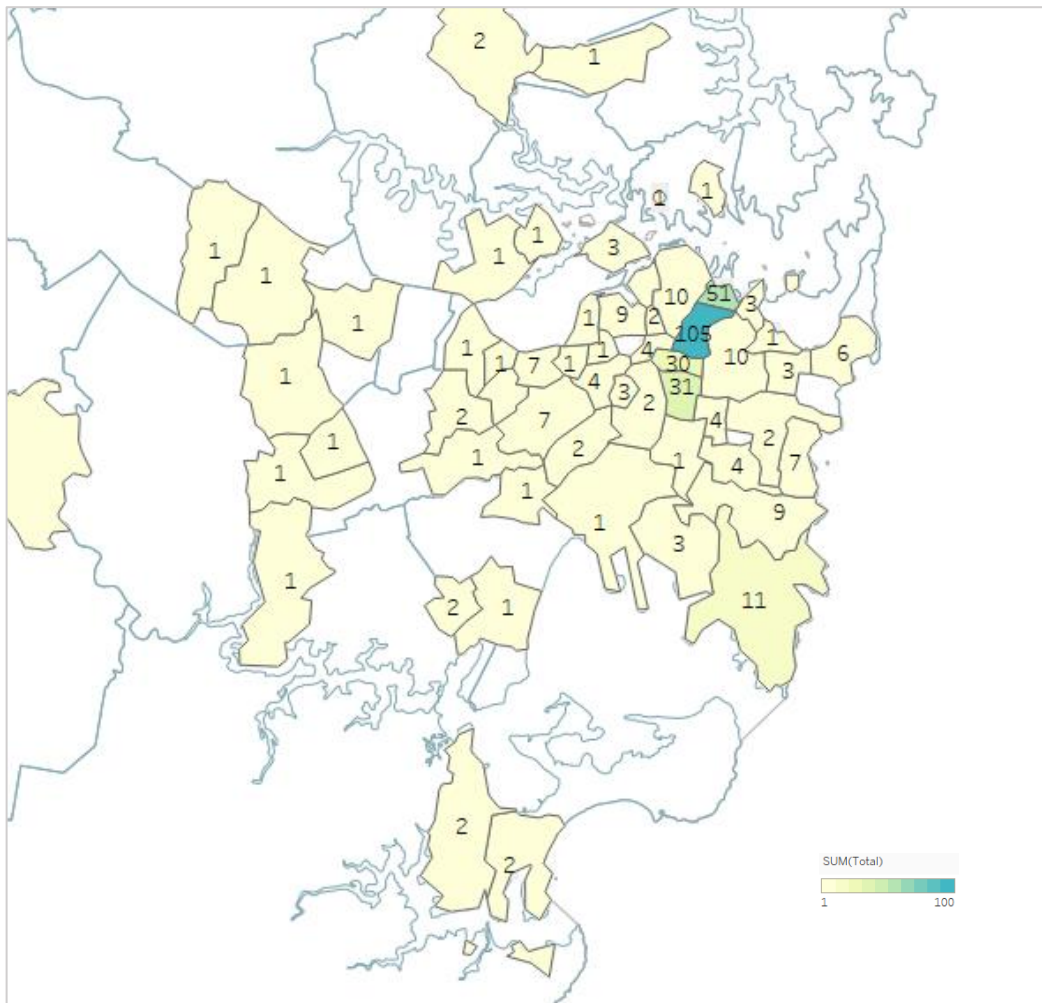
Figure 14. Total Yearly Outpatient Episodes 2013-2017



Between October 2017 and September 2018, 1,646 clients commenced an outpatient program with the ADS. This is 54 per cent of the 3,027 referrals received during this period, with the proportion of new clients ranging from 40 to 65 per cent of total monthly referrals. On average, the service accepted 137 new clients a month, with an average of six new clients on any given day. As at October 2018, there were 421 active clients with the service, of these 82 per cent (n=347) were self-referred.

Active clients are more heavily concentrated in the local area, with fewer clients from the wider metropolitan and greater Sydney area. Of active clients with a known postcode, 25 per cent (n=105) reside in Darlinghurst.

Figure 15. Outpatient Clients by Postcode (October 2018)



Source: CHIME

Of active clients as of October 2018, 76 per cent (n=318) were male and 7 per cent (n=29) identified as Aboriginal or Torres Strait Islander. 88 per cent (n=369) of clients were between the ages of 30 to 59 years, with the average age of clients being 45 years.

In 2017-18 the primary reasons for cessation of service were: completion of service at 72 per cent (n=1,197), followed by left against advice/without notice at 17 per cent (n=286). From clients who completed the service, 31 per cent (n=375) were referred to a GP and 22 per cent (n=267) were not provided any referral.

As seen from the tables below, episodes of care provided by the Stimulant Treatment Program over the last five years have grown significantly (Figures 16 and 17).

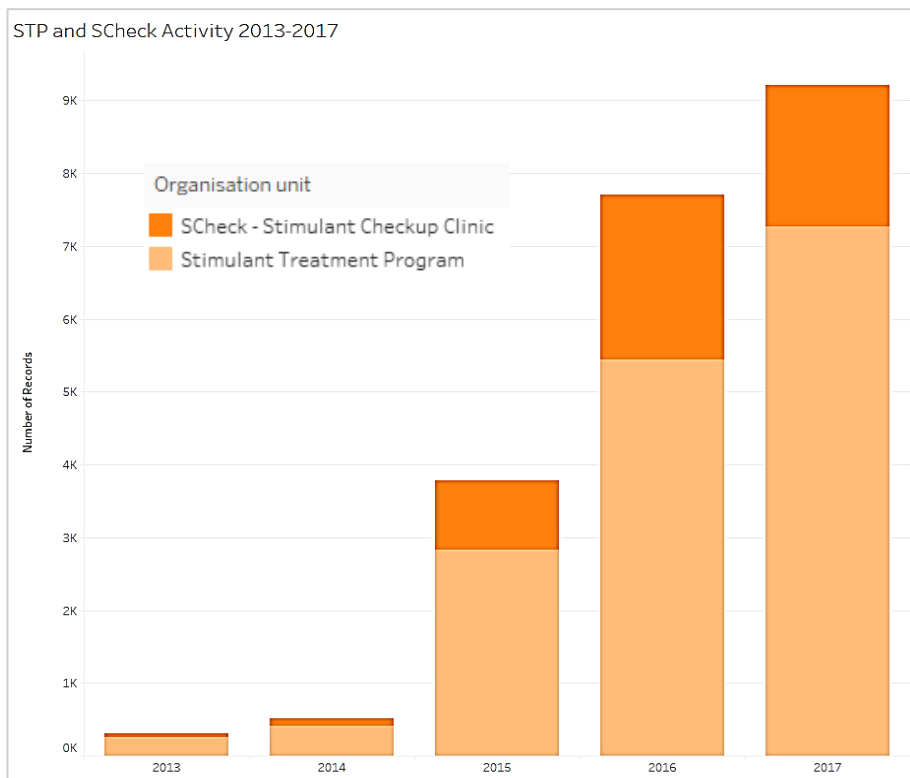
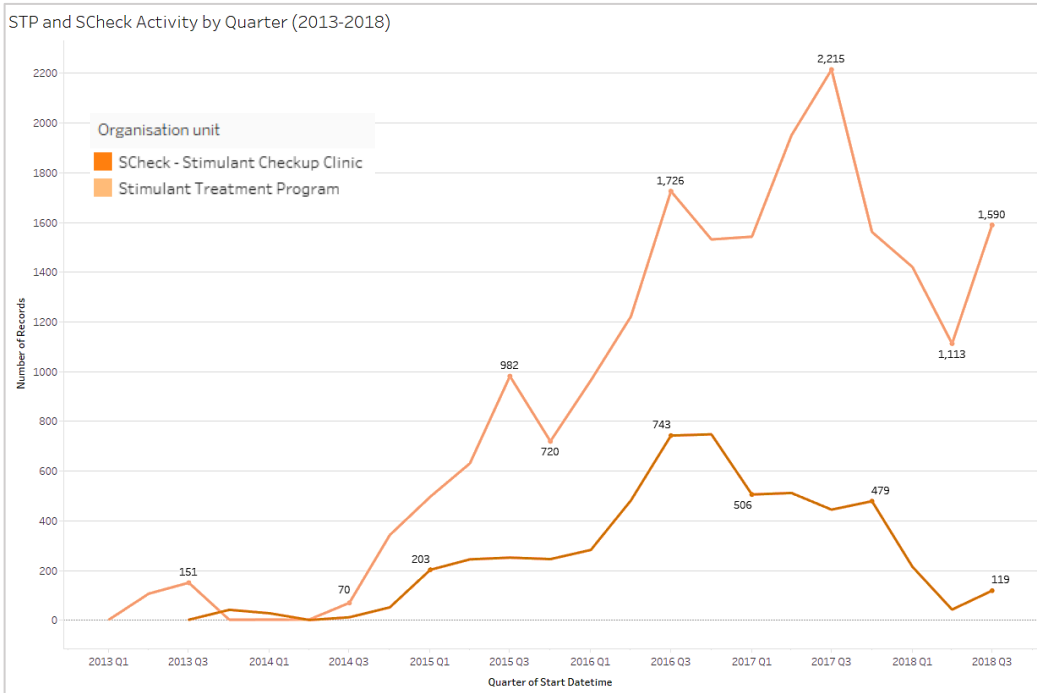


Figure 18 Monthly referrals to the Stimulant Treatment Program have also increased over the past year.

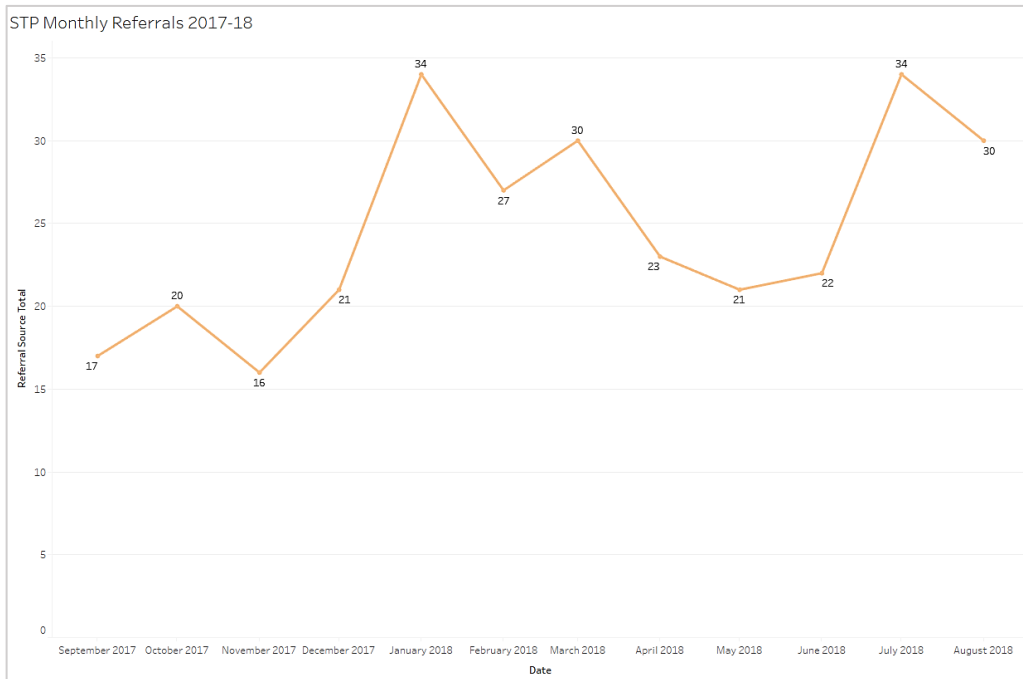
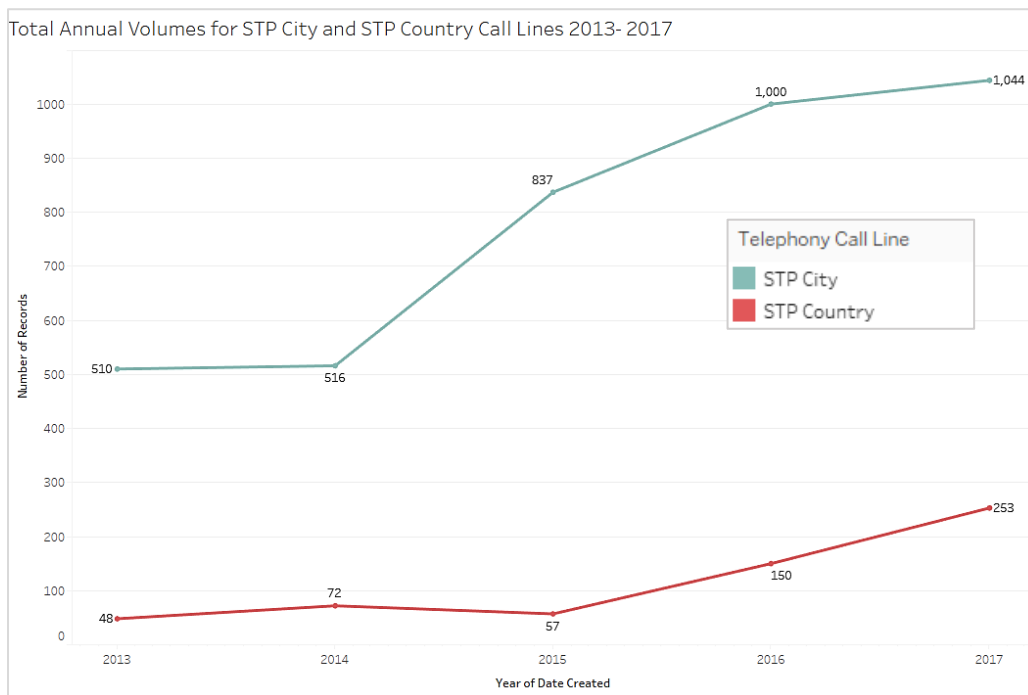


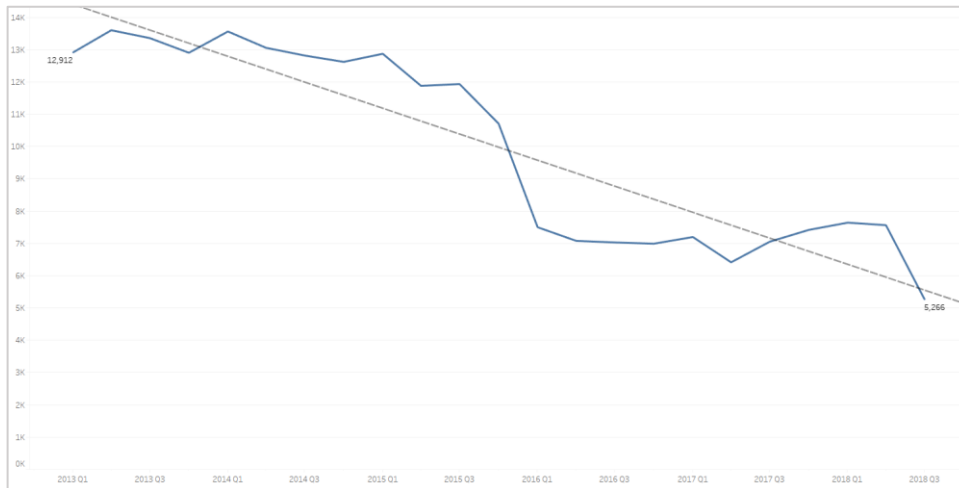
Figure 19 shows that calls to St Vincent’s Sydney’s Stimulant Treatment Line have increased between 2013-2017 for both city and country call lines.



3.5.5 Call Centre episodes

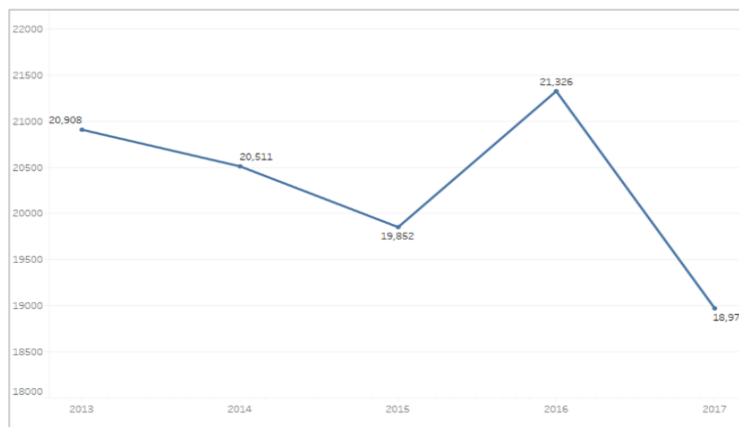
Over the previous five years, overall call centre episodes have decreased from 12,912 in the first quarter of 2013, to 5,266 in the third quarter of 2018 (Figure 20).

Figure 20. Contact Centre Episode Volumes 2013-2018



This decline has been impacted by the discontinued provision of some previous call lines (primarily NSW Quitline), however the total number of episodes related to SVHS' Alcohol and Drug Information Service (ADIS) – a 24/7, NSW state-wide telephone service providing education, information, referral, crisis counselling and support around substance use – have also decreased from 20,908 calls in 2013, to 18,972 in 2017 (Figure 21). This is a nation-wide trend, with calls dropping across State and Territory ADIS.

Figure 21. ADIS Episode Volumes 2013-2017



Across all call lines, the majority of episodes are attributable to ADIS. Between 2017-2018, 59.9 per cent (n=17,983) of all episodes were from ADIS. Comparatively, 4 per cent (n=1,280) of episodes were from the DASAS line. As per the table that appears on the next page, the total number of daily episodes is highly variable.

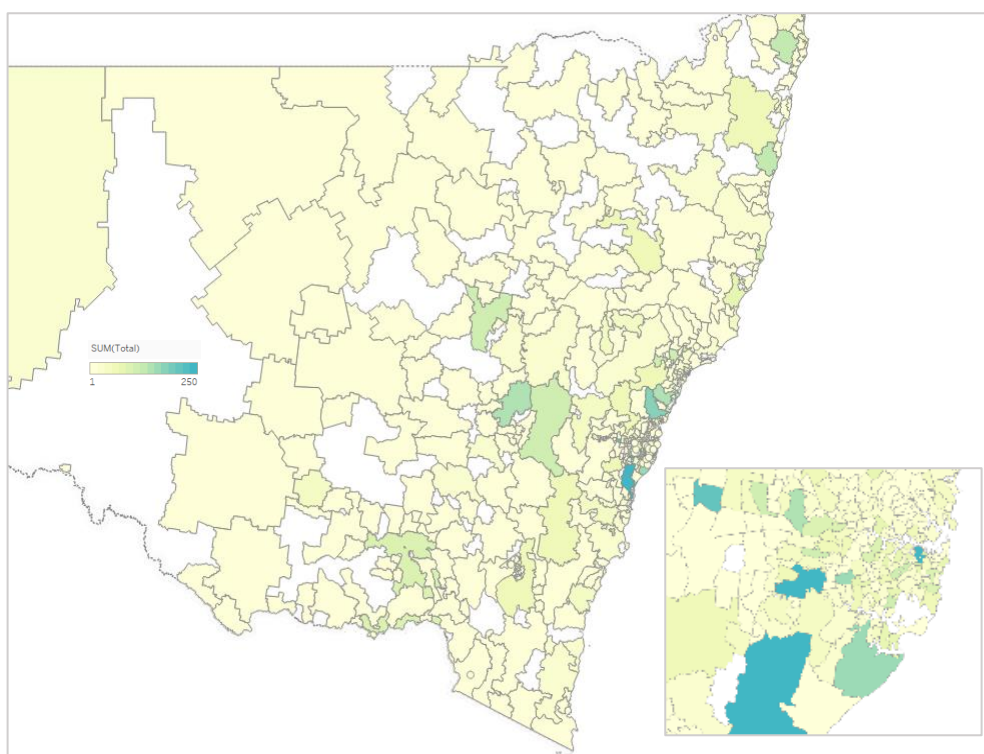
Call Line	Total Episodes	% of Total Episode Volume	Highest Number of Daily Episodes	Lowest Number of Daily Episodes	Average Daily Episode Volume
ADIS	17,983	59.9%	108	1	49.3
Gorman Overflow	5,244	17.5%	13	1	3.9
OTL	1,720	5.7%	16	1	6.3
STP	1,678	5.6%	17	1	4.9
DASAS	1,280	4.3%	13	1	3.9
WA Overnight	908	3.0%	11	1	2.8
Quit ACT	617	2.1%	9	1	2.3
Other*	590	2.0%	9	1	2.3
Total	30,020	100%	146	20	82.6

Note: Volumes reported from Sept 1st 2017 to August 31st 2018

*Other calls consists of: 1300DRIVER, Cannabis Caution, general staff and administration calls

A large number of episodes (approximately 20 per cent) were unable to be attributed to a valid post code. However, from 2017/18 data, the highest total number of episodes was from the Darlinghurst postcode (n=507), followed by Newcastle (n=381), Liverpool (n=367) and Wollongong (n=318). Comparatively, there were very few episodes from across regional and remote areas (Figure 22).

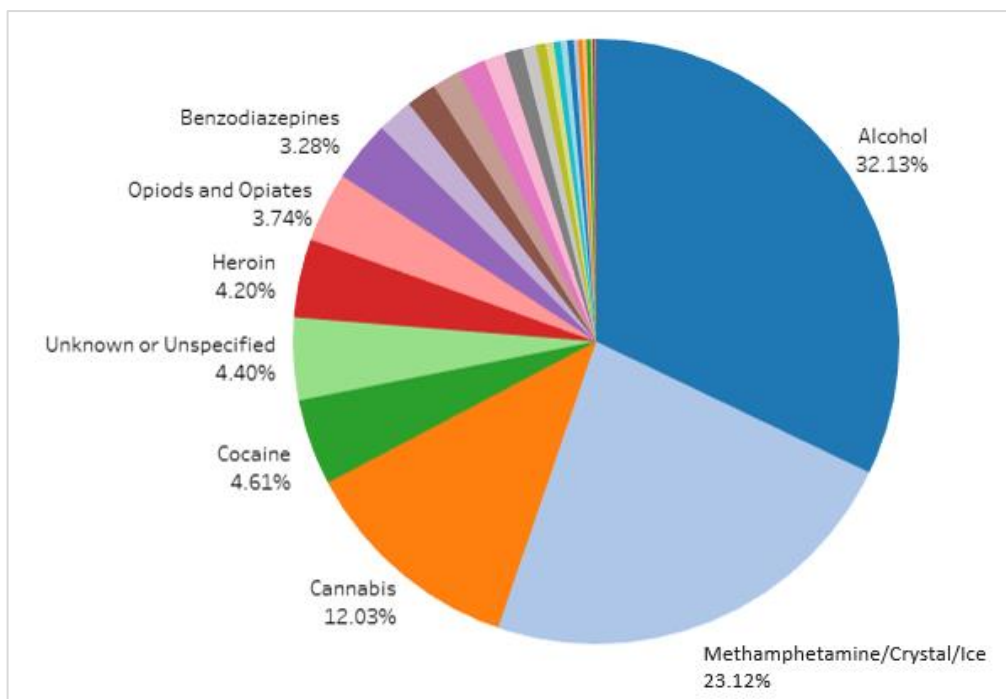
Figure 22. Contact Centre Episodes by Postcode 2017-18



Although demographic information was withheld in many instances, on average there are more male callers (60 per cent) and very few callers below the age of 19 (2 per cent), or over 60 (5 per cent). From the professional callers, one third were GPs, followed by Hospital Doctors/Medical Officers and Hospital Nurses at 22 and 16 per cent respectively. Approximately 80 per cent of non-professional callers were calling related to self. Other callers identified as parents (40 per cent), partners (17 per cent), friends (14 per cent) and siblings (11 per cent).

For ADIS calls, information is collected on substance of concern. Between September 2017 and August 2018, the majority of episodes were related to Alcohol, Methamphetamine/Crystal/Ice and Cannabis (Figure 23). There is a large spread of other types of substances.

Figure 23. ADIS Substance of Concern 2017-2018



Over time, the proportion of alcohol related episodes has remained relatively constant. However, the proportion of episodes related to Crystal/Ice and Cocaine have increased, while episodes related to Cannabis, Heroin and Opioid/Opiates has slightly decreased. The proportion of Methamphetamine episodes has remained relatively constant.

Figure 24: shows that ADIS calls related to Methamphetamine/Crystal/Ice increased significantly between 2013-16, followed by a decrease in 2017.

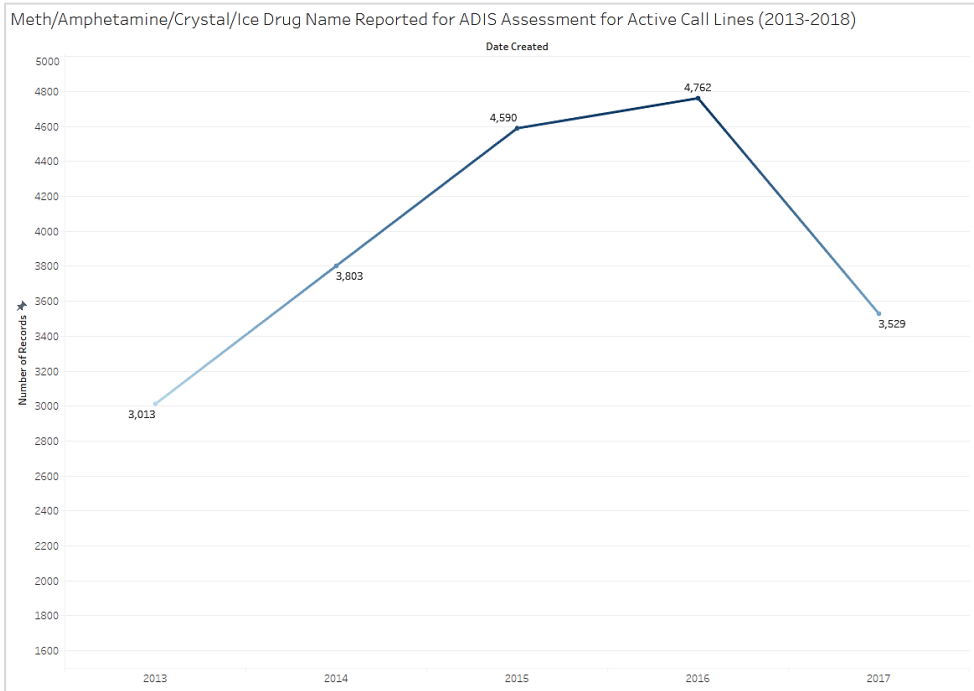


Figure 25 While between September 2017 and August 2018, ADIS calls related to Methamphetamine/Crystal/Ice have varied.

