Country SA PHN

Drug and Alcohol Treatment Activity Work Plan 2016-17 to 2018-19

phn COUNTRY SA

An Australian Government Initiative

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Strategic Vision for Drug and Alcohol Treatment Funding

The Country SA Primary Health Network's (CSAPHN) Strategic Vision for Drug and Alcohol treatment will align to Draft National Drug Strategy (NDS) 2016-2025 which aims to:

"Contribute to ensuring safe, healthy and resilient Australian communities through minimising alcohol, tobacco and other drug-related health, social and economic harms among individuals, families and communities."

Our Strategic Vision is also heavily informed by the key directions of:

- the National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014-19,
- the recommendations of the National Ice Action Strategy 2015 – particularly in ensuring that early intervention and treatment services are better tailored and responsive to meet the needs of the populations they serve – and;
- in line with key aspects of recently announced reforms relating to increasing the service delivery capacity of the drug and alcohol treatment sector via needs based commissioning to rural and remote South Australians.

CSAPHN acknowledges the three pillars of the NDS that underpin a harm minimisation approach (demand reduction, harm reduction and supply reduction) and will aim to commission drug and alcohol activity with aims towards:

- reducing the adverse health, social and economic consequences of the use of drugs and alcohol through effective in scope treatment services;
- support people to recover from dependence and reintegrate with the community and;
- to prevent the uptake and/or delay the onset of the use of drugs and alcohol.

To achieve our vision and goals CSAPHN is committed to the establishment and strengthening of governance arrangements and strategic collaboration with regional stakeholders including Local Health Networks, State Government and specialist drug and alcohol service providers.

Population estimates indicate that more than two thirds of individuals with a drug and alcohol use disorder have at least one comorbid mental health disorder; however, the rate is even higher among those in drug and alcohol treatment programs.

Because of this significant relationship, CSAPHN will strive towards improving the effectiveness of drug and alcohol treatment services for individuals requiring support and treatment by increasing coordination between mental health and other various sectors, to improve sector efficiency and the overall patient journey.

2. (a) Planned activities: Drug and Alcohol Treatment Services – Operational and Flexible Funding

Proposed Activities	
Drug and Alcohol Treatment Priority Area / Reference (e.g. Priority Reference 1, 2, 3)	**CSAPHN Needs Assessment identified priority** **1.0 Mental Health & Drug and Alcohol Comorbidity**
Activity Title / Reference (e.g. Activity 1.1, 2.1, etc.)	**1.1** Improved specialist training and adherence to evidence based treatment approaches and better cross sector referral and integration processes
Description of Drug and Alcohol Treatment Activity	**1.1 Aim** To reduce the harm associated with untreated co-occurring mental health and drug and alcohol conditions **How will this address the priority area?** Respondents to the CSAPHN Mental Health & Alcohol and Other Drugs (MHAOD) ITA process were requested to submit a treatment model - inclusive of stepped care principles and specialist workforce skills and training – that interfaces with mental health services in the identification and/or treatment of people with co-occurring mental health and drug and alcohol conditions. **Target Population** People presenting to drug and alcohol services with co-occurring mental health conditions **How is this aligned to CSAPHN Objectives?** • improving coordination of care to ensure patients receive the right care in the right place at the right time - *via adoption of the stepped care model across Mental Health and Drug and Alcohol.* **Drug and Alcohol Treatment Services – Operational and Flexible Funding Key Objective(s)**

	• Facilitate and support evidence-based treatment for clients using a range of substances, as well as flexible and stepped care models tailored to individual need and stage of change; • Promote linkages with broader health and support services, including mental health services, to better support integrated/ coordinated treatment and referral pathways to support clients with comorbid mental health disorders.
Collaboration	Drug and Alcohol specific stakeholder groups targeted for collaboration and engagement include: • DASSA - state/territory government services relating to drug and alcohol; policy priorities, sector arrangements, information sharing, collaborative planning; • SANDAS - peak body for drug and alcohol services; representing the non-government organisation (NGO) drug and alcohol sector, supporting two-way channels of communication, supporting sector development through specific capacity building activities • AHCSA and ADAC - Indigenous organisations including Aboriginal Community Controlled Health Organisations (ACCHOs) and Indigenous-specific drug and alcohol treatment services; Indigenous-specific need, service delivery expertise, knowledge of treatment population and service gaps specific to Indigenous populations. • AIVL - peak body for drug and alcohol users; representing the views of those with current/former drug and alcohol use experiences, some of whom may be in need of treatment and/or have treatment experience • Specialist drug and alcohol treatment providers in the region; treatment and service delivery expertise, knowledge of the local treatment population and of service gaps (including government and NGO drug and alcohol treatment services, plus GP pharmacotherapy prescribers). Within the stepped care approach of the MHAOD ITA, CSAPHN was seeking evidence of establishment and formalization of partnerships between potential drug and alcohol providers and services in the region to facilitate 'joined up' service provision, specifically between the: • mental health sector • broader primary health care environment • acute services • community services • aged care services • child and youth services

	• social services • Aboriginal health services All applicants were required to provide a response indicating how their proposed model would support partnerships, clinical handover and linkages. Including where applicable, how their intervention model will: • incorporate and formalise effective mechanisms to enable appropriate clinical handover of an individual's care. • ensure an individual's transition through the steps of care are seamless and appropriate. • have systems in place to support the integration and coordination of services. • support referrers, in particular General Practice, to ensure individuals are appropriately triaged to the most suitable "stepped-level" of treatment available. • support referrers, in particular General Practice, to ensure individuals are jointly monitored to determine the selected treatment effectiveness and further care decisions. • interact with the broader social services sector. • engage with the local health networks and acute sector.
Indigenous Specific	This activity is inclusive of Aboriginal and Torres Strait Islander people but not specific.
Duration	Potential 1 to 3 years depending on sustainability, review and ongoing contestability.
Coverage	As per MHAOD ITA defined regions (see appendix A)
Commissioning approach	Where applicable Country SA PHN as adopted a competitive Most Capable Provider (MCP) approach to the market as a tendering and contract mechanism for 2016/17. The approach was adapted to be competitive through an Invitation to Apply (ITA) process as a means of pre-selection. This approach to procurement was primarily chosen to: • identify the most appropriate providers within streams of activity and regions of CSAPHN to engage with for progression and development of in scope and needs based treatments;

	• seek innovative solutions and collaborative approaches by engaging with potential providers in developing service activity that would better address co-occurring drug and alcohol and mental health conditions. In rural and remote areas, we also have unique issues surrounding provider numbers and recruitment and retention of staff and a smaller pool of providers within some of our markets. As stated above, the adopted MCP ITA process is designed to promote innovation and collaboration in developing service solutions to better address rural and remote needs and service gaps, specifically in the area of co-occurring mental health and drug and alcohol conditions There are a number of considerations that are taken into account when assessing an organisation's suitability for funding. These considerations are important as they help to ensure that: • Clients receive timely access to treatment where possible; • Clients are safe when receiving treatment; • Clients with complex needs receive any broader support required; • Organisations are able to continue to learn and improve their service delivery; • Clients receive the best possible outcomes; and • Organisations do not seek to operate beyond their capacity. CSAPHN has also established an Independent Commissioning Committee (ICC) to assist in the commissioning process by providing independent expertise in the evaluation, review and approval of proposals for services and contracts valued at more than $200K arising from any tender process.
Local Performance Indicator target	The local performance of the provider will be monitored against indicators based on the following Results Based Accountability Measures where appropriate: i. Measurables a. # of people presenting b. # of people engaged (more than 3 sessions) c. # outreach services d. # referrals received e. # referrals made for clinical admissions for rehabilitation/detoxification f. # cross sectoral referrals to or from mental health based services

	ii. Quality a. % from priority groups b. % completing (strength based goal achievement cessation/decrease AOD) c. % satisfied with service d. % assessed within week iii. Outcomes a. # & % increased social connections b. # & % decrease AOD misuse c. # & % participants able to effectively deal with problems and challenges through self-management d. # & % participants show increased protective factors

Proposed Activities	
Drug and Alcohol Treatment Priority Area / Reference (e.g. Priority Reference 1, 2, 3)	**CSAPHN Needs Assessment identified priority** **2.0 Identified need of increased Drug & Alcohol Counselling services in following areas:** • Alcohol • Amphetamines (including methamphetamines/crystal methamphetamine) • Cannabis • Benzodiazepines and Illicit Opioids
Activity Title / Reference (e.g. Activity 1.1, 2.1, etc.)	**2.1 Commission additional drug & alcohol treatment services targeting the priority areas identified in the Needs Assessment**
Description of Drug and Alcohol Treatment Activity	**Aim** Increase service delivery capacity for drug and alcohol counselling services through:

	• Co-Design of additional activity with providers - pending successful applicant process - to increase specialist workforce capacity to support delivery of additional drug and alcohol services in targeted areas of need across rural and remote country areas • Upskilling across existing drug and alcohol programs by facilitating and supporting evidence based treatment for clients using a range of substances **How will this address the priority area?** Through the MHAOD ITA process the PHN will seek to commission additional intervention related services aimed at providing the client with the necessary psychological and physical resources to change drug and alcohol related behaviour. This intervention is considered a specialist drug and alcohol intervention and includes case management, motivational interviewing, relapse prevention, cognitive behaviour therapy and other psychological therapies as required by the client to address alcohol/drug use and associated harm. Applicants are requested to submit a model inclusive of stepped care principles and interface with mental health services **Target population** • Youth, adults, families and communities • People with co-occurring mental health and drug and alcohol conditions • Aboriginal and Torres Strait Island people **How is this aligned to CSAPHN Objectives?** • improving coordination of care to ensure patients receive the right care in the right place at the right time - *via adoption of the stepped care model across Mental Health and Drug and Alcohol.* • increasing service delivery capacity of the drug and alcohol treatment sector based on identified needs of clients. **Drug and Alcohol Treatment Services – Operational and Flexible Funding Key Objective(s)** • Facilitate and support evidence-based treatment for drug and alcohol clients who are users of a range of substances, as well as flexible and stepped care models tailored to individual need and stage of change.

Collaboration	Drug and Alcohol specific stakeholder groups targeted for collaboration and engagement include: • DASSA - state/territory government services relating to drug and alcohol; policy priorities, sector arrangements, information sharing, collaborative planning; • SANDAS - peak body for drug and alcohol services; representing the non-government organisation (NGO) drug and alcohol sector, supporting two-way channels of communication, supporting sector development through specific capacity building activities • AHCSA and ADAC - Indigenous organisations including Aboriginal Community Controlled Health Organisations (ACCHOs) and Indigenous-specific drug and alcohol treatment services; Indigenous-specific need, service delivery expertise, knowledge of treatment population and service gaps specific to Indigenous populations. • AIVL - peak body for drug and alcohol users; representing the views of those with current/former drug and alcohol use experiences, some of whom may be in need of treatment and/or have treatment experience • Specialist drug and alcohol treatment providers in the region; treatment and service delivery expertise, knowledge of the local treatment population and of service gaps (including government and NGO drug and alcohol treatment services, plus GP pharmacotherapy prescribers). Within the stepped care approach of the MHAOD ITA, CSAPHN was seeking evidence of establishment and formalization of partnerships between potential drug and alcohol providers and services in the region to facilitate 'joined up' service provision, specifically between the: • mental health sector • broader primary health care environment • acute services • community services • aged care services • child and youth services • social services • Aboriginal health services

	All applicants were required to provide a response indicating how their proposed model would support partnerships, clinical handover and linkages. Including where applicable, how their intervention model will: • incorporate and formalise effective mechanisms to enable appropriate clinical handover of an individual's care. • ensure an individual's transition through the steps of care are seamless and appropriate. • have systems in place to support the integration and coordination of services. • support referrers, in particular General Practice, to ensure individuals are appropriately triaged to the most suitable "stepped-level" of treatment available. • support referrers, in particular General Practice, to ensure individuals are jointly monitored to determine the selected treatment effectiveness and further care decisions. • interact with the broader social services sector. • engage with the local health networks and acute sector.
Indigenous Specific	This activity is inclusive of Aboriginal and Torres Strait Islander people but not specific.
Duration	Potential 1 to 3 years depending on sustainability, review and ongoing contestability.
Coverage	As per MHAOD ITA defined regions (see appendix A)
Commissioning approach	Where applicable Country SA PHN as adopted a competitive Most Capable Provider (MCP) approach to the market as a tendering and contract mechanism for 2016/17. The approach was adapted to be competitive through an Invitation to Apply (ITA) process as a means of pre-selection. This approach to procurement was primarily chosen to: • identify the most appropriate providers within streams of activity and regions of CSAPHN to engage with for progression and development of in scope and needs based treatments; • seek innovative solutions and collaborative approaches by engaging with potential providers in developing service activity that would better address co-occurring drug and alcohol and mental health conditions.

	In rural and remote areas, we also have unique issues surrounding provider numbers and recruitment and retention of staff and a smaller pool of providers within some of our markets. As stated above, the adopted MCP ITA process is designed to promote innovation and collaboration in developing service solutions to better address rural and remote needs and service gaps, specifically in the area of co-occurring mental health and drug and alcohol conditions There are a number of considerations that are taken into account when assessing an organisation's suitability for funding. These considerations are important as they help to ensure that: • Clients receive timely access to treatment where possible; • Clients are safe when receiving treatment; • Clients with complex needs receive any broader support required; • Organisations are able to continue to learn and improve their service delivery; • Clients receive the best possible outcomes; and • Organisations do not seek to operate beyond their capacity. CSAPHN has also established an Independent Commissioning Committee (ICC) to assist in the commissioning process by providing independent expertise in the evaluation, review and approval of proposals for services and contracts valued at more than $200K arising from any tender process.
Local Performance Indicator target	The local performance of the provider will be monitored against indicators based on the following Results Based Accountability Measures where appropriate: i. Measurables a. # of people presenting b. # of people engaged (more than 3 sessions) c. # outreach services d. # referrals received e. # referrals made for clinical admissions for rehabilitation/detoxification f. # cross sectoral referrals to or from mental health based services

	ii. Quality a. % from priority groups b. % completing (strength based goal achievement cessation/decrease AOD) c. % satisfied with service d. % assessed within week iii. Outcomes a. # & % increased social connections b. # & % decrease AOD misuse c. # & % participants able to effectively deal with problems and challenges through self-management d. # & % participants show increased protective factors

Proposed Activities	
Drug and Alcohol Treatment Priority Area / Reference (e.g. Priority Reference 1, 2, 3)	CSAPHN Needs Assessment identified priority **3.0 Deficit of Residential and non-residential rehabilitation options for Drug and Alcohol**
Activity Title / Reference (e.g. Activity 1.1, 2.1, etc.)	3.1 Undertake further in depth needs assessment, service planning, modelling and assessment of the current drug and alcohol treatment system capacity to meet required demand for current and future non-residential rehabilitation 3.2 Review and assess feasibility of residential rehabilitation services as sustainable options for drug and alcohol treatment services in country SA.
Description of Drug and Alcohol Treatment Activity	**3.1 Aim – Non -residential Rehabilitation**

	3.1.1 Through the current CSAPHN ITA process assess market response and capability to deliver additional non-residential rehabilitation services under the current service model arrangements to meet areas of need. This will include consideration of access to: • Addiction medicine specialists • Upskilling of and access to GPs with drug addiction skills • Specialist counselling and support through drug and alcohol workers and allied health professionals • Day Stay and other intensive non-residential programs **3.2 Aim** **Residential Treatment and Rehabilitation services in country SA** 3.2.1 Commence work to establish the base case for residential rehabilitation service demand in country SA through service planning and modelling - using the DA-CCP tool when available for SA 3.2.2 Encourage and nurture cross sector referral and integration within CSAPHN MHAOD comorbidity reform agenda. 3.2.3 Undertake further market analysis of bed based treatment and rehabilitation models that could meet specific needs of rural and remote clients (informed by planning and service modelling) **How will this address the priority area?** ***Non- Residential Rehabilitation*** Through the ITA process the PHN will seek to commission additional non-residential rehabilitation services. These could include day programs of intensive, structured interventions to address psychosocial causes of drug dependence though evidence-based treatment. Services provided will be person-centred rehabilitation services. ITA respondents will be requested to submit a model inclusive of stepped care principles and interface with mental health services ***Residential Rehabilitation*** Further detailed modelling (utilising DA-CCP) and planning to better assess need and location for residential based drug and alcohol treatment and rehabilitation will inform future commissioning strategies as well as any 'rebalancing" of services to meet need.

	3.4 Target population Youth and Adults - Indigenous and non-Indigenous- who have been assessed and referred for specialist treatment and rehabilitation as the result of problematic alcohol and/or other drug use. Services will also focus on people with co-occurring mental health and drug and alcohol conditions through adherence to the evidence based National Co-Morbidity Treatment Guidelines **How is this aligned to CSAPHN Objectives?** • improving coordination of care to ensure patients receive the right care in the right place at the right time in line with a best practice stepped care approach • increasing service delivery capacity of the drug and alcohol treatment sector based on identified needs of clients **Drug and Alcohol Treatment Services – Operational and Flexible Funding Key Objective(s)** • Address the increased demand for access to drug and alcohol treatment – which may be attributable to increasing methamphetamine use – through needs based and targeted planning in response to the changing needs of the community • Facilitate and support evidence-based treatment for clients using a range of substances, as well as flexible and stepped care models tailored to individual need and stage of change
Collaboration	**Non-residential Rehabilitation Services** All respondents to the ITA must provide a response indicating how their proposed service model will support partnerships, clinical handover and linkages. Including where applicable, how their intervention model will: • incorporate and formalise effective mechanisms to enable appropriate clinical handover of an individual's care. • ensure an individual's transition through the steps of care are seamless and appropriate. • have systems in place to support the integration and coordination of services. • support referrers, in particular General Practice, to ensure individuals are appropriately triaged to the most suitable "stepped-level" of treatment available. **Residential Rehabilitation Services**

	Collaborate with Commonwealth and State based health and drug and alcohol agencies and services to develop and test the Service Planning Model tool (DA-CCP). Development of the planning tool for SA will help inform priority setting and resource allocation decisions to meet future demand – including residential treatment and rehabilitation services.
Indigenous Specific	This activity is inclusive of Aboriginal and Torres Strait Islander people but not specific.
Duration	**Non-residential rehabilitation** - potential 1 to 3 years depending on sustainability, review and ongoing contestability **Residential Rehabilitation** – target 2018/19 pending outcome of detailed modelling and further commissioning work.
Coverage	As per MHAOD ITA defined regions (see appendix A)
Commissioning approach	Where applicable Country SA PHN as adopted a competitive Most Capable Provider (MCP) approach to the market as a tendering and contract mechanism for 2016/17. The approach was adapted to be competitive through an Invitation to Apply (ITA) process as a means of pre-selection. This approach to procurement was primarily chosen to: • identify the most appropriate providers within streams of activity and regions of CSAPHN to engage with for progression and development of in scope and needs based treatments; • seek innovative solutions and collaborative approaches by engaging with potential providers in developing service activity that would better address co-occurring drug and alcohol and mental health conditions. In rural and remote areas, we also have unique issues surrounding provider numbers and recruitment and retention of staff and a smaller pool of providers within some of our markets. As stated above, the adopted MCP ITA process is designed to promote innovation and collaboration in developing service solutions to better address rural and remote needs and service gaps, specifically in the area of co-occurring mental health and drug and alcohol conditions There are a number of considerations that are taken into account when assessing an organisation's suitability for funding. These considerations are important as they help to ensure that: • Clients receive timely access to treatment where possible;

	• Clients are safe when receiving treatment; • Clients with complex needs receive any broader support required; • Organisations are able to continue to learn and improve their service delivery; • Clients receive the best possible outcomes; and • Organisations do not seek to operate beyond their capacity. CSAPHN has also established an Independent Commissioning Committee (ICC) to assist in the commissioning process by providing independent expertise in the evaluation, review and approval of proposals for services and contracts valued at more than $200K arising from any tender process.
Local Performance Indicator target	The local performance of the provider will be monitored against indicators based on the following Results Based Accountability Measures where appropriate: i. Measurables a. # of people presenting b. # of people engaged (more than 3 sessions) c. # outreach services d. # referrals received e. # referrals made for clinical admissions for rehabilitation/detoxification f. # cross sectoral referrals to or from mental health based services ii. Quality a. % from priority groups b. % completing (strength based goal achievement cessation/decrease AOD) c. % satisfied with service d. % assessed within week iii. Outcomes a. # & % increased social connections b. # & % decrease AOD misuse

	c. # & % participants able to effectively deal with problems and challenges through self-management d. # & % participants show increased protective factors

Proposed Activities	
Drug and Alcohol Treatment Priority Area / Reference (e.g. Priority Reference 1, 2, 3)	**CSAPHN Needs Assessment identified priority** **4.0 Drug and Alcohol Attributable Hospital Separations**
Activity Title / Reference (e.g. Activity 1.1, 2.1, etc.)	4.1 Improved post discharge service planning including relapse prevention through effective aftercare support services for Drug and Alcohol attributable hospital admissions/separations
Description of Drug and Alcohol Treatment Activity	**4.1 Aim - Review and improve Discharge Planning for Drug and Alcohol attributable separations** Investigate discharge planning processes across the acute sector and research best practice models to inform project design enabling improvements in the continuity of care. **How will this address the priority area?** Analysis of all rural and remote hospital admissions and separations and readmissions that identify alcohol and problematic drug as the main attributable factor to: • establish baseline hospital admission/separation rates for whole of CSAPHN region as well by regional areas • identify, analyse and investigate any significant variations by region population, age, sex, Indigenous or non-Indigenous • Based on data analysis develop a Project Plan to review and improve discharge planning processes targeting key areas of high rates in the first instance **Target Population**

	Youth and Adults - Indigenous and non-Indigenous- who have been (admitted and) discharged from acute hospital based care as the result of problematic alcohol and/or other drug use including amphetamines **How is this aligned to CSAPHN Objectives?** • improving coordination of care to ensure patients receive the right care in the right place at the right time in line with a best practice stepped care approach • increasing service delivery capacity of the drug and alcohol treatment sector based on identified needs of clients **Drug and Alcohol Treatment Services – Operational and Flexible Funding Key Objective(s)** • Address the increased demand for access to drug and alcohol treatment – which may be attributable to increasing methamphetamine use – through needs based and targeted planning in response to the changing needs of the community • Facilitate and support evidence-based treatment for clients using a range of substances, as well as flexible and stepped care models tailored to individual need and stage of change
Collaboration	Initial consultation/collaboration will be with the Local Health Networks (Country and Metropolitan) to access relevant drug and alcohol hospital admission, separation and readmission data for country residents Project development to address the priority of discharge planning will include broader consultations with state and territory health services and other relevant stakeholders including Local Hospital Networks (LHNs), Aboriginal Community Controlled Health Organisations (ACCHOs), and other services provided by the non-government sector
Indigenous Specific	This activity is inclusive of Aboriginal and Torres Strait Islander people but not specific.
Duration	1-3 years
Coverage	As per MHAOD ITA defined regions (see appendix A)

Provisional Local Performance Indicator targets	Possible LPIs could be inclusive of: Project implementation Other Performance Indicators will be defined during project development, and may include: • Type of referral on discharge from acute care • Client uptake of referral pathway • Readmission rates Project implemented within agreed timeframe and agreement reached with CHSALHN to provide required data Increase in mental health/drug and alcohol discharge referrals for drug and alcohol related admissions from baseline FY 2014-15 Agreed % of clients attend initial referral Agreed % of clients' complete treatment initiated by discharge referral Reduction in readmission rates (within a timeframe TBD). Baseline to be calculated when data is made available

2.(b) Planned activities: Drug and Alcohol Treatment Services for Aboriginal and Torres Strait Islander people – Flexible Funding.

Proposed Activities	
Drug and Alcohol Treatment Priority Area / Reference (e.g. Priority Reference 1, 2, 3)	**CSAPHN Needs Assessment identified priority** **1.0 Improved consultation and engagement with Aboriginal and Torres Strait Islander specific Drug and Alcohol sector**
Activity Title / Reference (e.g. Activity 1.1, 2.1, etc.)	1.1 Building strengths, resilience, partnerships & capacity in drug and alcohol activities within Aboriginal Torres Strait Islander communities 1.2 Commission culturally appropriate evidenced based treatment services for Aboriginal and Torres Strait Islander people, targeted co-planning and co- design with Aboriginal Corporation (ADAC) and Aboriginal Community Controlled Health Organisations (ACCHOs) to realign currently funded and new activity within CSAPHN drug and alcohol scope and funding. 1.3 Engage with local communities and consult with relevant local indigenous and mainstream primary health care organisations to identify the specific drug and alcohol needs of Aboriginal and Torres Strait Islander people
Description of Drug and Alcohol Treatment Activity	**1.1 Aim of activity** To work with Aboriginal and Torres Strait Islander community organisations/ACCHOs to identify any current shortcomings and discuss and develop potential strategies to support ACCHO's to promote greater competitiveness in tendering for commissioned services. In consultation with ACCHOs, develop and implement a Stakeholder Engagement Framework for the PHN. Establish a joint high level drug and alcohol annual planning forum between CSAPHN, SA Aboriginal Health Council and CSALHN to identify shared high level priorities for service delivery. **How the activity will address the priority?**

	This will address priority by working towards and commissioning activity with integration of clinical services with cultural competency and vice versa. **Target population cohort** Aboriginal Torres Strait Islander communities across CSAPHN region **1.2 Aim of activity** Commission joint service mapping exercise across CSAPHN and ACCHO/ Aboriginal and Torres Strait Islander communities using market analysis for successful models via ITA process and expansion of services through targeted commissioning to meet areas of need. Further engagement and consultation with the ACCHO and Aboriginal and Torres Strait Islander community sector to identify areas for improved service linkages and interface between drug and alcohol, primary health care and Hospital services. **How will this address the priority area** Will support to build capacity and capability of current and potential service providers through access to culturally responsive and appropriate activity. **Target population** Aboriginal and Torres Strait Island people and communities across the CSAPHN region. **1.3 Aim of activity** To determine the most appropriate mix of service delivery modalities for commissioning in each region, developing partnerships within Aboriginal and Torres Strait Islander communities to implement community specific responses and support models and identify needs targeted to individual or small groups of individual communities. **How the activity will address the priority?** Engagement with local communities will allow needs to be regionally targeted to individuals as well as small groups of individual communities **Target population cohort** Aboriginal and Torres Strait Island people and communities across the CSAPHN region.

	How is this aligned to CSAPHN Objectives? • improving coordination of care to ensure patients receive the right care in the right place at the right time - *via adoption of the stepped care model across Mental Health and Drug and Alcohol.* • working with other funders of services and purchasing or commissioning health and medical/clinical services for local groups most in need. **Drug and Alcohol Treatment Services for Aboriginal and Torres Strait Island people – Flexible Funding Key Objective(s)** • Address the increased demand for access to methamphetamine, alcohol and other drug treatment — through needs based and targeted planning in response to the changing needs of the community. • Facilitate and support evidence-based treatment for clients using methamphetamine, alcohol and other drugs, as well as flexible and stepped care models tailored to individual need and stage of change;
Collaboration	Collaboration across CSAPHN region with mainstream Local Health Networks, NGOs, GPs and private health providers. A commitment to consultation, co-design and collaboration with peak bodies Aboriginal Drug & Alcohol Council (SA) Aboriginal Corporation (ADAC) and Aboriginal Health Council of South Australia (AHCSA), as well as local ACCHOS.
Duration	Engagement with ACCHO sector and other relevant stakeholders and drug and alcohol service mapping: 2016/17
Coverage	As per MHAOD ITA defined regions (see appendix A)
Commissioning approach	CSAPHN's approach is committed to commissioning evidence-based drug and alcohol clinical services that are in line with a best practice stepped care approach and that: • provides a range of services to meet local community needs; • makes the best use of available workforce and technology; • ensures drug and alcohol workforce skills and qualifications are commensurate with the level of service being commissioned; • complements and links to other closely connected services; • are integrated across the whole drug and alcohol, mental health system and other health services

	• have the flexibility to enable service provision to be adjusted to address new and emerging priorities and/or hot spots • are culturally appropriate and meet the needs and preferences of patients, their families and communities. CSAPHN's commissioning approach will also be strongly underpinned by the principle of cultural competency. This means commitment to ensure that commissioning activities will: • Develop and improve the cultural competence of service providers to ensure all services meet the needs and preferences of Aboriginal and Torres Strait Islander people. • Establish linkages between commissioned and existing services to enable a joined approach with other closely connected services including social and emotional wellbeing, suicide prevention and alcohol to enhance and better integrate Aboriginal and Torres Strait Islander drug and alcohol services at the local level • Establish referral pathways and follow up services to support patients • Provide information to patients about how to access other services in a crisis situation • Establish joined up assessment processes and referral pathways enabling patients to seamlessly transition between services as required. The CSAPHN will work with ACCHO sector to establish the key success factors when commissioning Indigenous specific drug & alcohol services and programs
Provisional Local Performance Indicator targets	Demonstrated implementation of the Principles and criteria set down in the "Implementation Plan for the National ATSI Health Plan 2013-2023 Demonstrated application of the above principles and approach when commissioning Indigenous specific drug and alcohol programs and services through inclusion in CSAPHN commissioning framework. Comprehensive mapping of drug and alcohol provided by Indigenous health organisation or services provided to Aboriginal and Torres Strait Islander people

Proposed Activities	
Drug and Alcohol Treatment Priority Area / Reference (e.g. Priority Reference 1, 2, 3)	**CSAPHN Needs Assessment identified priority** **1. Brief intervention, withdrawal management and counselling with alcohol and amphetamines focus**

Activity Title / Reference (e.g. Activity 1.1, 2.1, etc.)	2.1 Address increased demand for access to Aboriginal and Torres Strait Islander specific methamphetamine, alcohol and other drug treatment

Description of Drug and Alcohol Treatment Activity	2.1.1 Undertake further needs based and targeted planning in response to changing needs of community having due regard to currently funded service capacity and ability to meet emerging service demands.
	
	2.1.2 Identify, in consultation with Aboriginal Community Controlled Health Organisations (ACCHO) sector and other organisations providing services for Indigenous people, what additional service delivery capacity is required to meet the demand for amphetamine, alcohol and other drug treatments including:
	
	• Early intervention services (screening and brief intervention)
	• Treatment services including:
	  ○ Counselling
	  ○ Withdrawal management
	  ○ Residential Rehabilitation
	  ○ Day stay (other non –residential programs)
	  ○ Case management
	• Relapse Prevention – Aftercare support
	
	How will this address the priority area?
	
	Will support to build capacity and capability of the drug and alcohol treatment service system, including within the Aboriginal and Torres Strait Islander controlled services and their workforce.
	
	Will support region specific, cross sectoral and integrated approaches to methamphetamine, alcohol and other drug treatment services based on identified need.
	
	Will promote improved access to culturally responsive and appropriate programs to address problematic drug and alcohol use-including amphetamine/methamphetamines
	
	Will strengthen partnerships and collaboration between Aboriginal and Torres Strait Islander controlled services, government and mainstream providers and health organisations in planning, delivery and evaluation of services
	
	Target population

	Aboriginal and Torres Strait Island people – individual, families and communities. Other drug and alcohol services providing services to Indigenous people **How is this aligned to CSAPHN Objectives?** • improving coordination of care to ensure patients receive the right care in the right place at the right time in line with a best practice stepped care approach. • Address the increased demand for access to drug and alcohol treatment – which may be attributable to increasing methamphetamine use – through needs based and targeted planning in response to the changing needs of the community. **Drug and Alcohol Treatment Services for Aboriginal and Torres Strait Island people – Flexible Funding Key Objective(s)** To ensure targeted and culturally appropriate drug and alcohol treatment services for Aboriginal and Torres Strait Islander people which link to broader Indigenous health services Facilitate and support evidence-based treatment for clients using methamphetamine, alcohol and other drugs, as well as flexible and stepped care models tailored to individual need and stage of change; Promote linkages with broader culturally appropriate health and support services, including mental health services, to better support integrated/ coordinated treatment and referral pathways to support Aboriginal and Torres Strait Islander people with comorbid mental health disorders
Collaboration	CSAPHN will work in collaboration with ACCHO sector to develop commissioning processes that build on capacity and support ATSI organisations to minimise fragmentation This will give consideration to currently funded services, as well as consultations with state and territory health services and other relevant stakeholders including Local Hospital Networks (LHNs), ACCHOs, and other services provided by the non-government sector.
Duration	New services commissioning from 2016/17

Coverage	As per MHAOD ITA defined regions (see appendix A)
Commissioning approach	CSAPHN's approach is committed to commissioning evidence-based drug and alcohol clinical services that are in line with a best practice stepped care approach and that: • provides a range of services to meet local community needs; • makes the best use of available workforce and technology; • ensures drug and alcohol workforce skills and qualifications are commensurate with the level of service being commissioned; • complements and links to other closely connected services; • are integrated across the whole drug and alcohol, mental health system and other health services • have the flexibility to enable service provision to be adjusted to address new and emerging priorities and/or hot spots • are culturally appropriate and meet the needs and preferences of patients, their families and communities. CSAPHN's commissioning approach will also be strongly underpinned by the principle of cultural competency. This means commitment to ensure that commissioning activities will: • Develop and improve the cultural competence of service providers to ensure all services meet the needs and preferences of Aboriginal and Torres Strait Islander people. • Establish linkages between commissioned and existing services to enable a joined approach with other closely connected services including social and emotional wellbeing, suicide prevention and alcohol to enhance and better integrate Aboriginal and Torres Strait Islander drug and alcohol services at the local level • Establish referral pathways and follow up services to support patients • Provide information to patients about how to access other services in a crisis situation • Establish joined up assessment processes and referral pathways enabling patients to seamlessly transition between services as required. The CSAPHN will work with ACCHO sector to establish the key success factors when commissioning Indigenous specific drug & alcohol services and programs
Provisional Local Performance Indicator targets	Consultation process undertaken • Aligned with the key performance indicators for Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health and substance misuse Commissioning of new services/realignment of funding undertaken

	Indigenous people accessing services Ultimately a reduction in Indigenous people requiring acute care for amphetamine and alcohol misuse and this could potentially be detected through monitoring of the inpatient separations and ED presentations data base. However, any effect is not likely to be detectable during the initial reporting time frame of this activity. Annual data analysis will be initiated to detect and monitor any longer term trends. Aboriginal and Torres Strait Islander peoples' view social and emotional wellbeing in a different way to non- Indigenous concepts of mental health and wellbeing, mental illness and drug and alcohol issues. While non Indigenous mental health and wellbeing focuses largely on the ability of the individual to function within their environment, Aboriginal and Torres Strait Islander social and emotional wellbeing encompasses not only the wellbeing of the individual, but also the wellbeing of their family and community. It reflects a holistic understanding of life and health which includes mental health, but also considers other factors such as cultural, spiritual and social wellbeing. The report Key performance indicators for Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health and substance misuse in Queensland21 identified indicators under three domains: Health and wellbeing status / outcomes 1. Psychological distress (social and emotional wellbeing) 2. Racism and resilience (social and emotional wellbeing) 3. Suicide (social and emotional wellbeing / mental health) 4. Hospitalisations: mental and behavioural disorders (mental health) 5. Hospitalisations: psychoactive substance use (substance misuse) 6. Alcohol-related mortality (substance misuse) Health system performance 7. Mental health / social and emotional wellbeing service gap (social and emotional wellbeing / mental health) 8. Pre-admission community care for mental health patients (mental health)

	9. Post-discharge community care for mental health patients (mental health) 10. Alcohol, tobacco and other drugs service gap (Substance misuse) 11. Access to community controlled health services (social and emotional wellbeing / mental health / substance misuse) 12. Aboriginal and Torres Strait Islander staff in mainstream services (social and emotional wellbeing / mental health / substance misuse) Social and cultural determinants 13. Connectedness to culture and community 14. Early childhood development 15. Child protection 16. Contact with the criminal justice system 17. Income As part of CSAPHN MHAOD comorbidity priority the above findings would be considered when developing culturally appropriate local indicators and service measures as part of our capacity building agenda surrounding ACCHOs.

Appendix A


Coober Pedy
Outback
Roxby Downs
Far West
Ceduna
Port Augusta
Whyalla
Port Pirie
Eyre and Flinders
Yorke and Northern
Kadina
Nuriootpa
Berri
Riverland
Port Lincoln
Mount Barker
Murray Bridge
Murray Mallee
Kangaroo Island
Victor Harbor
Limestone Coast
Mount Gambier
Regional Service Areas:
Barossa - Gawler
Hills - Fleurieu
Kangaroo Island
Limestone Coast
Murray Mallee
Yorke and Northern
Eyre and Flinders
Riverland
Far West
Outback
Adelaide PHN