Alcohol and Other Drugs Regional Needs Assessment Update 2017-2018
Table of Contents

ACKNOWLEDGEMENT ........................................................................................................... 2

COMPANION DOCUMENTS ................................................................................................. 2

SECTION 1- INTRODUCTION ................................................................................................. 3

   National Alcohol and Other Drugs reform ....................................................................... 4
   Methodology ...................................................................................................................... 5

SECTION 2 – OUTCOMES OF THE HEALTH NEEDS ANALYSIS ..................................... 6

SECTION 3 – OUTCOMES OF THE SERVICE NEEDS ANALYSIS .................................... 23

SECTION 4 – OPPORTUNITIES, PRIORITIES AND OPTIONS ......................................... 37

SECTION 5 - REFERENCES .................................................................................................. 44
Acknowledgement

The updated Mental Health (MH) and Alcohol and Other Drugs (AOD) planning for the Northern Queensland Primary Health Network (NQPHN) was conducted in late 2017 in collaboration between the NQPHN Mental Health Team and Population Health and System Team.

The members of the NQPHN team included Gillian Yearsley, Sandi Wanner, Charmaine Knox, Gaynor Ellis and Bernie Triggs.

Members of the Population Health and System team include Frankie Clive, Adnan Choudhury, Paraniala Silas C Lui, Elizabeth Mitchell and Penny Edwards.

The NQPHN also wishes to acknowledge the contribution of its Clinical Councils, Staff, Regional panthers, Health Care Service Providers and the residents of Northern Queensland.

Companion Documents

NQPHN Mental Health Planning Framework 2016
NQPHN Needs Assessment 2016
NQPHN Mental Health and Suicide Prevention Needs Assessment 2016
NQPHN Alcohol and Other Drugs Needs Assessment 2016
Improving Mental Health Services in the Primary Health Care Sector – NQPHN Overview (A3 document) 2017
NQPHN Mental Health and Suicide Prevention Regional Plan 2017
NQPHN Alcohol and Other Drugs Regional Plan 2017
Section 1- Introduction

Primary Health Networks (PHNs) were established in 2015 by the Australian Government with the aim of increasing the efficiency and effectiveness of medical services for people (particularly those at risk of poor health outcomes) and improving coordination of care to ensure people receive the right care in the right place at the right time.

One of the key roles of the Northern Queensland Primary Health Network (NQPHN) is to lead the planning and commissioning of regional Alcohol and Other Drugs (AOD) services with a focus on coordination to ensure better outcomes for individuals and their families.

This document contains updated information supplementing the initial AOD needs assessment conducted in 2016-17. The AOD priorities as identified in the initial Health Needs Assessment remain relevant and key priorities areas for the NQPHN:

- Improve coordination between sectors to address co-existing AOD misuse and mental health issues (dual diagnosis issues)
- Increase capacity of the PHC workforce and other sectors to support AOD needs
- Increase access to AOD services for young people
- Increase availability of local withdrawal management and support services
- Increase supply of health promotion, early intervention and prevention programs
- Improve support and expand appropriate services for Aboriginal and Torres Strait Islander people in the region
- Develop program to support transitional pre and post-prison release services for people with AOD issues
- Raise awareness of the impact of AOD on infants and children (Fetal alcohol spectrum disorder - FASD)

The NQPHN has been tasked with the planning and commissioning of drug and alcohol treatment services to reduce the risks of harm associated with drugs and alcohol in the community. There is a stated focus on methamphetamine use and planning and commissioning for Aboriginal and Torres Strait Islander specific services. The regional approach to Alcohol and Other Drugs planning will take into account the following key factors:

- the spectrum of needs within the population and effective responses
- the range of settings through which services are delivered
- the diverse social contexts of northern Queensland
- considerations that may vary according to user characteristics (e.g. gender, race, particular substance, comorbidity with mental disorders, forensic considerations etc).

Drawing from this process and the collective regional knowledge about what works in our region, the NQPHN will develop a Regional Alcohol and Other Drugs Plan. This plan will be guided by local contextual considerations and developed in partnership
with key stakeholders such as state and national peak bodies, local hospital networks, non-government organisations and other specialised service providers including Aboriginal and Torres Strait Islander organisations and general practices.

**National Alcohol and Other Drugs reform**

The Commonwealth Government’s AOD policy directions and priorities are articulated within the following key reports and policy documents:

- *Australian Government’s Response to the National Ice Taskforce’s Final Report 2015*
- *The National Ice Action Strategy 2015*
- *The National Drug Strategy 2011*
- *Queensland Alcohol and Other Drugs Treatment Service Delivery Framework, March 2015*
- The Alcohol and Other Drug service planning guidance materials developed by the Australian Government for the Primary Health Networks (2016)

The Commonwealth Department of Health has developed specific guidance materials for the PHNs in their commissioning of AOD treatment services. The intention for the AOD funding is that it will:

- increase the service delivery capacity of the drug and alcohol treatment sector through the commissioning of additional methamphetamine, alcohol and other drug treatment services
- improve the effectiveness of drug and alcohol treatment services by increasing coordination between various sectors and improving sector efficiency.

The funding will provide additional methamphetamine, alcohol and other drug treatment services for clients, their families, and the community through primary care and specialist services.

The following types of treatments and services are in scope for funding by the NQPHN:

- **early intervention** targeting less problematic drug use, including brief intervention counseling
- **withdrawal management** with pathways to post-acute withdrawal support and relapse prevention
- **residential rehabilitation** with pathways to post-acute withdrawal support and relapse prevention
- **day stay rehabilitation** and other intensive non-residential programs
- **post treatment support and relapse prevention**
- **case management, care planning, and coordination**
- **supporting the workforce** undertaking these service types through activities which promote joint assessment processes and referral pathways and **support continuous quality improvement, evidence based treatment** and service integration.
Methodology

NQPHN has carried out extensive stakeholder consultation and engagement across the region during the initial needs assessment, service mapping, co-design, and planning workshops for MH and AOD in 2016 and early 2017. Over 600 people participated in these workshops, consultations and online community surveys, representing a cross-section of the footprint including the following:

- General Practice
- Non-Government Organisations (NGOs)
- Aboriginal and Torres Strait Islander Health Authorities
- Local Government Areas (LGAs)
- Allied Health – Public and Private
- Queensland Health
- NQPHN Clinical Council
- Consumers

Information collated from these consultations and engagements are reviewed and triangulated with existing data from the initial AOD Needs Assessment 2016/2017 and integrated together with relevant literature to inform this current update. Qualitative data including an online key informant survey and co-design workshops across the region are incorporated in the update. New data and information are added within this AOD Needs Assessment and where applicable, some evidence has been removed and/or restructured to reflect the current health needs of the communities. The most recent secondary data available during the collection and/or presented to NQPHN were used for the overall Health Needs Assessment. The data sources included:

- Australia Bureau of Statistics (ABS), 2016 census
- Australian Institute of Health and Welfare (AIHW) data
- Queensland Health
- Australian Government Department of Health-PHN data
- Chief Health Report-data 2016
- Department of Aboriginal and Torres Strait Islander Partnerships community profiles
- Public Health Information Unit (PHIDU), Social Atlas of Australia, Torrens University
- Queensland Regional Profiles
SECTION 2 – OUTCOMES OF THE HEALTH NEEDS ANALYSIS

This section summarises the findings of the AOD health needs analysis in the table below.

<table>
<thead>
<tr>
<th>Identified Need</th>
<th>Key Issue</th>
<th>Description of Evidence</th>
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<tbody>
<tr>
<td>Alcohol and Other Drugs use</td>
<td>High alcohol and drug use in the region</td>
<td>In 2016, nationally it was estimated that approximately 77% of Australians aged 14 and over drank alcohol in the previous 12 months and approximately 12% smoke tobacco daily. Approximately 1 in 5 (17%) people drank at high-risk levels over their lifetime, and 26% of people drank at high risk levels at least once a month that makes them vulnerable to accident or injuries (Australian Institute of Health and Welfare, 2017). Approximately 2 in 5 (43%) people aged 14 and over are estimated to be using illicit drug during their lifetime while 16% of people have used illicit drug in the past 12 months. Local data (Burdekin-17.8%, Cairns-18.7%, Cassowary Coast-18.4%, Charters Tower-20.2%, Hinchinbrook-20.2%, Isaac-22.7%, Mackay-19.4%, Palm Island-20.2%, Tablelands-19.8%, Townsville-19.1%, Whitsunday-20.4%, Yarrabah-17.5%) indicated higher proportion of people aged 15 years and over drinking two or more alcohol drinks daily on average compared to Queensland state (17.2%). Similar estimations are also noted for daily smoking amongst people aged 18+ years in the region (PHIDU, 2017). The data also indicated that in the NQPHN region the most commonly cited drug of concern was alcohol (60%), followed by cannabis and amphetamine (9%) (Queensland Network of Alcohol and Other Drug Agencies LTD, 2016).</td>
</tr>
</tbody>
</table>
### Outcomes of the health needs analysis

<table>
<thead>
<tr>
<th>Social determinants of AOD</th>
<th>Socioeconomic and social acceptance of alcohol</th>
</tr>
</thead>
<tbody>
<tr>
<td>People with lower socioeconomic status (socially disadvantaged population) tend to consume large quantities of alcohol per occasion (Roche et al., 2015). However, socioeconomic status may interact with other demographic factors (gender and age) to influence alcohol consumption. Approximately 39% (n=12) of LGAs within NQPHN fall in the two most disadvantaged index (IRSD score), (National Mental Health Commission, 2017). The prevalence of alcohol consumption within the region (at each LGA) is generally higher than the state average (PHIDU, 2017). A qualitative study amongst community leaders and service providers in 15 Aboriginal communities in the footprint consistently reported illicit alcohol supply and consumption as an issue (Fitts et al., 2017). This may be attributed to the high percentage of disadvantaged communities, availability and social acceptance of alcohol within the communities.</td>
<td></td>
</tr>
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</table>

| Social impacts and determinants of drug use | Harmful AOD use causes significant harm to individuals, families and communities. However, it is important that harmful AOD use in any community is not considered in isolation as there are many contributing factors that often vary with the type of drug. For example, harmful AOD use is linked with poorer health outcomes, including increased risk of disease and injury and shortened life expectancy, which then lead to increased costs to the health and hospital systems and also the deterioration of family and community. Harmful AOD use can also adversely affect a person’s education, employment, health and involvement with the criminal justice system which can have a whole-of-life and, in many cases, intergenerational impact. ¹ As identified in the needs assessment, drug use can have a significant impact on disadvantaged groups and lead to intergenerational patterns of disadvantage. There is strong evidence of an association between social determinants— |
| Overall, alcohol misuse is responsible for 3.2% of the total burden of disease and injury in Australia. Within NQPHN’s region, 45% of the population are in the lowest and most disadvantaged group (SEIFA, ABS), and in Torres and Cape York this proportion is 74%. The NQPHN has an average unemployment rate of 8.5% compared to 6.2% (Queensland) as of March quarter 2017. This ranges from 2.9% in Weipa to 66.6% in Arukun. 10.4% of the NQPHN population are in low-income brackets ($0-650/week) compared to 9.4% across Queensland. The figure in some remote communities is far higher such as Wujal Wujal at 45.8% (Queensland Government Statistician's Office, 2017). In 2015-16 there was an increase in drug related offences in the Queensland Police Service regions that align with the NQPHN catchment: 8% increase in Northern region and 6% in Central region (Queensland Police Service, 2016). |

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¹ National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014 - 2019
Outcomes of the health needs analysis

| Health disparities for Aboriginal and Torres Strait Islander people related to alcohol and other drugs use |  
|---|---|
| such as unemployment, homelessness, poverty, and family breakdown, and drug use. Socio-economic status has been associated with drug related harms such as fetal alcohol syndrome, alcohol and other drug disorders, hospital admissions due to diagnoses related to alcoholism, lung cancer, drug overdoses and alcohol-related assault. Managers of facilities reported that they sometimes felt the services were used as a 'dumping ground' for people with mental health issues and those being released from prison or on parole. They stated that there is no specific funding available to facilitate meaningful transition from mental health and corrective facilities for people with AOD issues. All Managers thought that there is a need for 'step-out' facilities for people to go when they are in transition to rehabilitation facilities. | There is strong evidence to suggest that the population is subject to increased rates of domestic and family violence, family breakdown and child neglect as a result of high rates of substance misuse. Cairns Magistrates Court is the sixth busiest court in Queensland with 1,178 Domestic Violence Protection Order (DVPO) applications processed in 2013-2014. | Surveys of AOD use are of varying quality and consistency and always underestimate actual consumption, however, they indicate that levels of harmful use among Aboriginal and Torres Strait Islander Australians are about twice those in the non-Indigenous population. At a National level:  
- illicit drugs are estimated to cause 3.4% of the burden of disease and 2.8% of deaths, compared to 2.0% and 1.3% among the non-Indigenous population nationally  
- Aboriginal and/or Torres Strait Islander males are hospitalised for conditions to which alcohol makes a significant contribution at rates between 1.2 and 6.2 times those of non-Indigenous males |

| Aboriginal and Torres Strait Islander issues around AOD misuse are complex and multi causal and addressing these issues requires a comprehensive approach that considers social determinants, prevention, culturally safe care and treatment, and support to clients, families and communities. The Needs Assessment highlighted the correlation of suicide and self-harm with excessive substance use, specifically alcohol. Studies show that suicide was the most common cause of alcohol-related deaths among Aboriginal males and the fourth most common cause among Aboriginal females. Intentional injury is not the most common cause of alcohol-related death in non-Aboriginal population. |  
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3 Queensland Alcohol and Other Drugs Treatment Service Delivery Framework (March 2015)
## Outcomes of the health needs analysis

| Consultations through the NQPHN communities identified need at a community level for a holistic integrated approach to AOD treatment when the same staff treat both disorders in the same setting. This was particularly highlighted in communities that had Community Controlled Health Services. Other feedback around needs included: | • Aboriginal and/or Torres Strait Islander females are hospitalised for conditions to which alcohol makes a significant contribution at rates between 1.3 and 33 times greater compared to non-Indigenous females (including injuries related to assault) • Deaths from various alcohol-related causes are 5 to 19 times greater than among non-Indigenous Australians • In Queensland, from 1998 to 2006, two-thirds of Aboriginal and Torres Strait Islander people who died by suicide had consumed alcohol, and more than one-third had used drugs such as cannabis, amphetamines, inhalants or opiates at the time of their deaths. • Aboriginal community controlled health sector’s national report, as part of the online services report, identified amphetamines as a common substance-use issue which increased from 45% in 2013–14 to 70% in 2014–15 • In 2014–15, 57 organisations providing non-residential, follow up and after care services reported around 19,900 clients. This was similar to 2013–14 (around 20,100). • Most non-residential and after care clients were Indigenous (81%). More than half of all Indigenous clients (57%) were male and 39% were female. 43% of all Indigenous clients were aged 19 to 35 and a similar proportion (43%), were aged 36 and over. Clients aged 18 and under made up a smaller proportion (14%) of Indigenous clients. A landmark report on the burden of disease estimates for Aboriginal and Torres Strait Islander population noted; • Two-thirds of years lost among Indigenous Australians were due to poor health caused by mental health and substance use disorder, especially alcohol use disorder, anxiety and depression (39%) |
| • more education for schools and youth groups for prevention and early intervention including building resilience and coping strategies • culturally appropriate detoxification and residential rehabilitation services to effectively meet the needs of young people from rural and remote locations • opportunities for Aboriginal and Torres Strait Islander communities and services to develop their own AOD local area plans and strategies. |  |

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6 National Aboriginal and Torres Strait Islander Peoples’ Drug Strategy 2014 - 2019
Outcomes of the health needs analysis

| Increased consumption of alcohol and other drugs in rural and remote communities | The needs assessment highlighted the significant increased consumption of alcohol and other drugs within the rural and remote areas within the region. Rural people experience disproportionately high levels of alcohol misuse and its associated burden of disease and injury. This is due to a range of factors characteristic of rural areas including lack of venues for recreation, stoic attitudes about help-seeking, economic and employment disadvantage, and less access to healthcare professionals and alcohol treatment services.⁹ | The National Drug Strategy Household Survey report indicates that people living in remote and very remote areas were twice as likely as people in major cities to smoke tobacco daily, drink alcohol in risky quantities, and use methamphetamines in the previous 12 months. The proportion of those drinking at risky levels increases with increasing remoteness (Australian Institute of Health and Welfare, 2014). In a number of outer regional and rural/remote LGAs in NQPHN, the estimated number of people aged 18 years and over consuming more than two standard alcoholic drinks per day on average compared to Queensland (17.2%) (PHIDU, 2017); |

- Tobacco use (12%) and Alcohol use (8%) were 2 leading preventable risk factors causing the most burden among Indigenous Australians
- Over 50% of the disease burden attributed to alcohol use disorders for ages 15-44
- At the state level, mental & substance use disorders were leading cause to total disease burden (21%) for Aboriginal and Torres Strait Islander people in Queensland (Australian Institute of Health and Welfare, 2016a).

Data for the FNQ population indicates that Aboriginal and Torres Strait Islander people are over-represented in the criminal justice and child protection systems, with 55.9% of children in out-of-home care and with 71% of prisoners at Lotus Glen prison being of Aboriginal and Torres Strait Islander background.⁸ As noted earlier, a qualitative study amongst community leaders and service providers in 15 Aboriginal communities in the footprint consistently reported illicit alcohol supply and consumption as an issue (Fitts et al., 2017).

⁸ Cairns Alliance of Social Services: Position Paper 2016
⁹ National Rural Health Alliance (2014) Fact Sheet: Alcohol Use in Rural Australia March 2014
Outcomes of the health needs analysis

About one-third of the Australian population (or 6.6 million people) live in rural and remote areas. In those areas, alcohol consumption and its associated harms are consistently higher than in urban areas.

The AIHW has reported that among those living in rural areas, men and youths are particularly likely to drink at high-risk levels. Those working in the farming industry are also more likely to drink at risky levels.

- Burdekin (18.7%)
- Cassowary Coast (18.4%)
- Charters Towers (20.2%)
- Isaac (22.7%)
- Palm Islands (20.2%)
- Tablelands (19.8%)
- Whitsunday (20.4%)

Compared to non-Indigenous people, Aboriginal and Torres Strait Islander people (two-thirds of whom live in rural and remote areas) are 1.5 times more likely to drink at risky levels for both lifetime and single-occasion harm. This is despite the fact that Aboriginal and Torres Strait Islander Australians are also 1.4 times more likely to abstain from drinking alcohol.

From 1990–2001, alcohol-attributable death rates were consistently higher for rural residents than urban residents (2.2 per 10,000 persons compared with 1.7). Similarly, rates of hospitalisation attributed to alcohol were higher for rural than urban residents (48 per 10,000 compared with 37). In rural areas, one-third of those aged 14–19 years and two-thirds of those aged 20–24 reported that they have been victims of alcohol-related physical abuse. In some mining communities in Queensland with neighbouring work camps housing ‘fly-in, fly-out’ workers, the rate of alcohol-fuelled violence is significantly higher than the state average. ¹⁰

Stakeholder consultations and responses to the online survey identified a significant need in relation to the engagement of released prisoners with primary care. This included follow up in all communities within the region including remote communities. Suggestions included the need for services that provide

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¹⁰ National Rural Health Alliance (2014) Fact Sheet: Alcohol Use in Rural Australia March 2014
<table>
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<tr>
<th>Outcomes of the health needs analysis</th>
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<tbody>
<tr>
<td>an alternate ‘step out’/community reintegartion facility for prison release including care-coordination.</td>
</tr>
<tr>
<td>This link between drug and alcohol use and risk-taking behaviours leads to increased contact with the criminal justice system.</td>
</tr>
<tr>
<td>Evidence suggests a strong link between drug use and offending. Between 37 and 52% of adult offenders report their criminal activity is directly attributable to their drug problem.</td>
</tr>
<tr>
<td>Studies identified by Corrective Services Queensland include:</td>
</tr>
<tr>
<td>• 51% of men and 35% of women identified alcohol and/or drugs as the cause of their lifetime offending career</td>
</tr>
<tr>
<td>• 29% of offenders attributed their most serious current offence to drug and/or alcohol intoxication and 24% of offenders causally attributed their offending to drug and alcohol dependency</td>
</tr>
<tr>
<td>• 70% of juvenile detainees were intoxicated at the time of their offence</td>
</tr>
<tr>
<td>• homicide and assault offences were more likely to be attributed to alcohol intoxication while property, fraud and multiple offences were likely to be attributed to reported illegal drugs</td>
</tr>
<tr>
<td>• alcohol is involved in approximately half of all violent crime.</td>
</tr>
</tbody>
</table>
| • there is a high level of illicit drug use among offenders prior to their entry to the correctional system. 71% of prison entrants had used illicit drugs during the 12 months prior to their incarceration, with 60% reporting a history of injecting drug use. For male offenders, the most commonly used drugs in the community include cannabis, heroin, amphetamines, ecstasy and
### Outcomes of the health needs analysis

| Higher rates of risky alcohol consumption | The Needs Assessment identified in some areas in the NQPHN region that there is a high rate of people consuming alcohol and other drugs at harmful levels, which results in some people displaying risky behaviours. Alcohol-related harm is not limited to individual drinkers but impacts families and the broader community.

Alcohol is consumed widely in Australia. However, harmful levels of consumption are a major health issue, associated with increased risk of chronic disease, injury and premature death.  

The harmful use of alcohol has both short-term and long-term health effects. In the short term, the effects are mainly related to injury of the drinker or others that the drinker's behaviour affected. With its ability to impair judgment and coordination, excessive drinking contributes to crime, violence, anti-social behaviours and accidents. Over the longer term, harmful drinking may result in alcohol dependence and other chronic

Levels of risky drinking vary across HHS (Health of Queenslanders 2014). Based on those exceeding Guideline 1 (two or less standard drinks on any one day) and Guideline 2 (four or less standard drinks on any one occasion), in 2011–12 compared to the state prevalence:

- Guideline 1—three HHS in the NQPHN had higher rates (Cairns and Hinterland was 23% higher, Mackay 31% higher and Cape York and Torres Strait 34% higher)
- Guideline 2 (weekly)—Cairns and Hinterland, and Mackay were 35% higher.

As identified in the community consultations within the NQPHN region, alcohol is the most commonly cited (65%) principal drug of concern.

Rates of risky consumption of alcohol and other drugs (AOD) and related harms among Aboriginal and Torres Strait Islander Australians are generally twice those in the non-Indigenous population.  

The AIHW (2017) reported:

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11 Queensland Corrective Services: Alcohol and Drug Policy
12 Cairns Alliance of Social Services: Position Paper 2016
### Outcomes of the health needs analysis

| Conditions, such as high blood pressure, cardiovascular diseases, cirrhosis of the liver, types of dementia, mental health problems and various cancers. | 1 in 5 people in Australia drank alcohol at levels that increased their risk of harm over their lifetime (more than 2 standard drinks per day on average), while 26% of people drank more than 4 standard drinks at least once a month that put them at risk of accident or injury (Australian Institute of Health and Welfare, 2017). |
| High levels of AOD-related harm among Aboriginal and Torres Strait Islander Australians are both a consequence of, and contribute to, the health and social gap between them and non-Indigenous Australians. | almost 5 million Australians aged 14 or older (26%) had been a victim of an alcohol-related incident in 2013 with most of these incidents involving verbal abuse (22%); however, this proportion declined from 2010 (from 24% to 22%). A further 8.7% involved physical abuse and this remained relatively stable between 2010 (8.1%) and 2013. |

The Chief Health Officer report (2016) reported higher rates of lifetime risky drinking in the NQPHN region compared to the Queensland average (21.8%) in 2015/16 local regional level among persons 18+ years:

- Cairns & Hinterland (28.3%), Mackay (29.1%); Torres and Cape (27.8%) and Townsville (24.2%)

Higher rated were also noted for single occasion risky drinking at least monthly among persons 18+ years (31.8%, Queensland):

- Cairns & Hinterlands (37.4%), Mackay (35.7%), Torres and Cape (40.5%), Townville (34.5%)

The alcohol attributable hospitalisation rate was higher in the Cairns & Hinterland (10.8%) and Torres & Cape (16.4%) compared to Queensland (9.4%). The rates in Mackay (6.3%) and Townsville (7.7%) were lower. Overnight hospitalisation for AOD use was higher within the NQPHN region compared to the national average (180/100,000) at SA3 level (2014-15);

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## Outcomes of the health needs analysis

<table>
<thead>
<tr>
<th>Needs of marginalised groups within the region</th>
<th>Outcome Analysis</th>
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| Some culturally and linguistically diverse (CALD) populations may have higher rates of, or are at higher risk of, drug use. For example, some members of new migrant populations from countries where alcohol is not commonly used may be at greater risk when they come into contact with Australia's more liberal drinking culture. Some types of drugs specific to cultural groups, such as kava and khat, can also contribute to problems in the Australian setting. People from disadvantaged or marginalised groups, such as gay, lesbian, bisexual, transgender and intersex populations, may also experience more difficulty in accessing drug treatment and achieving successful outcomes from that treatment unless it is appropriate for their particular needs. | - Cairns-North (218/100,000)  
- Cairns South (212/100,000)  
- Innisfail-Cassowary Coast (181/100,000)  
- Tablelands (East)-Kuranda (258/100,000)  
- Whitsunday (234/100,000)  
- Far North (327/100,000)  
(Australian Institute of Health and Welfare, 2016b)  
Within the reform communities in Cape York, the evaluation of the Wellbeing Centres identified that they are having a clinically and statistically significant effect on their clients in reducing the level of risky drinking and the level of cannabis dependency.  
Ninety-five% of respondents to the online survey identified that alcohol is the main consumer substance of concern within the region.  

The patterns of alcohol and other drug use in gay, lesbian, bisexual, transgender and intersex populations communities differ when compared to the broader population, based on the limited data available that collect transgender, intersex, and sexuality indicators and non-LGBTI comparison groups. Risky alcohol use is higher among lesbian, gay, and bisexual (LGB) people than heterosexuals. The 2010 National Drug Strategy Household Survey (NDSHS) found that 26.5% of homosexual/bisexual people, compared with 15.8% of heterosexual people, reported weekly risky drinking, defined as more than four drinks on a single occasion.  
In 2011, the Far North region (including Cape York and remote communities) experienced the seventh highest rate of homelessness in Australia. However, |

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20 ACON, Health Outcome Strategy 2013 – 2018 – Alcohol and Other Drugs
<table>
<thead>
<tr>
<th>Outcomes of the health needs analysis</th>
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<tbody>
<tr>
<td>Those who are most at risk are people with multiple and complex needs. This may involve a combination of drug use, mental illness, disability and injury, family breakdown, unemployment, homelessness and/or have spent time in prison. ¹⁸</td>
</tr>
</tbody>
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Generally, Australia-wide rates of homelessness for Aboriginal and Torres Strait Islander Australians significantly outweighs that of the non-Indigenous population. The fastest growing group of homeless people are those living in severely overcrowded accommodation and at least 75% of Indigenous homeless people live in severely overcrowded dwellings - more than double the figure for non-Indigenous people. ¹⁹

Within the NQPHN region the needs of the homeless population in relation to drug and alcohol were identified as needing further exploration in collaboration with other government departments.

ABS data does not accurately reflect hidden homelessness such as overcrowding, couch sleeping and rough sleeping.

The National Drug Strategy Household survey reported that LGBTI in Australia were:
- 5.8 times likely to use ecstasy
- 4.5 times more likely to use Methamphetamines
- 2.9 times more likely to use cannabis
- 2.8 times more likely to use cocaine compared to non-LGBTI in the previous 12 months
- Higher proportion of smoking daily (21.4% vs 12.6%) compared to non-LGBTI


A priority area for Cairns Regional Council is addressing the needs of homeless people, in particular Cape York residents unable to return home.

Numbers of homeless people across the region from Australian Bureau of Statistics, 2012:
- Cape York and Torres Strait numbers are unavailable
- Cairns - 2303 homeless
- Mackay - 893 homeless
- Townsville - 1591 homeless

Headspace Centre report for the NQPHN catchment for FY 2015/16 (YTD to 31/12/15) indicates 9.5% of young people accessing centres within the region were homeless or at risk of homelessness.

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¹⁹ Cairns Alliance of Social Services: Position Paper 2016
### Outcomes of the health needs analysis

| Impact of alcohol and other drugs on infants and children | Fetal alcohol spectrum disorder (FASD) is the most common, preventable cause of disabilities and brain damage in children; it is triggered by exposure to alcohol during pregnancy. Fetal alcohol spectrum disorder causes lifelong disability due to intellectual impairment. FASD is the most common non-genetic cause of intellectual impairment in the western world. More children are born each year with FASD than with autism, spina bifida, cerebral palsy and Down syndrome combined. Between 17 and 42 children are born in Australia each day with FASD, between 3 and 9 of these in Queensland. (Total births ABS 2013). (QH statement) Alcohol is one of many substances that can result in damage to the unborn child if used during pregnancy. Others include some prescription medications and tobacco, marijuana, cocaine and other recreational drugs. To date the NQPHN has no access to specific data relating to effects of mothers drug use on unborn children. | Accurate data on the prevalence of FASD is needed to inform prevention strategies. At present there is no requirement to count or report FASD nationally. Stakeholder consultations identified that among Aboriginal and Torres Strait Islander children in North Queensland, fetal alcohol spectrum disorder has been identified as a major cause of impairment to normal physical and intellectual development. They also highlighted that is may be under-diagnosed because clinicians are reluctant to ask about prenatal alcohol exposure or to pursue potential diagnoses of FASD if positive. It has been estimated that child fetal alcohol spectrum disorder affects 1.5% of Aboriginal and Torres Strait Islander babies born in Far North Queensland and in some cases as high as 3.6%. At a national level in the Aboriginal population, 23% of birth mothers of Aboriginal children reported drinking alcohol in pregnancy. Whilst the rates of reported alcohol consumption in pregnancy are higher for non-Aboriginal women, Aboriginal women are more likely to consume alcohol at harmful levels. A Western Australian (WA) study of women who had given birth over a 10-year period, found that Aboriginal women were 10 times more likely to be diagnosed with an alcohol diagnosis when compared with non-Aboriginal women—23% and 2.3% respectively. 21 | Higher rates of cannabis use | Cannabis was identified across the NQPHN region as a major drug of concern. As identified by the Queensland Crime and corruption Commission, the cannabis market in Queensland is an established and stable market and In the NQPHN region the most commonly cited principal drug of concern is alcohol (65%) followed by cannabis (28%), and volatile solvents and amphetamines (2%). This is consistent with the cumulative data which shows alcohol as the most commonly cited principal drug of concern (42%), followed |

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### Outcomes of the health needs analysis

<table>
<thead>
<tr>
<th>cannabis use in Queensland is higher than the national average.</th>
<th>by amphetamines (24%) and cannabis (23%) (Queensland Network of Alcohol and Other Drug Agencies 2015).</th>
</tr>
</thead>
<tbody>
<tr>
<td>A number of short and long-term health effects have been associated with cannabis use. These include increased heart rate; a decrease in motivation, memory and attention; decreased motor skills; respiratory issues; anxiety, paranoia, depression, psychosis and addiction as well as the increased risk of developing more severe mental health disorders such as schizophrenia.</td>
<td>Recent data indicated in NQPHN footprint during 2015-16, Cannabis (37.6%) was cited as the most common principal drug of concern followed by Alcohol (31.3%), and Amphetamines (14.7%), (AIHW Data, 2017).</td>
</tr>
<tr>
<td>Consultations identified that in some communities, cannabis is so common that it is de-problematised – but it is a major social and health issue.</td>
<td>Consultations identified that in some communities, cannabis is so common that it is de-problematised – but it is a major social and health issue.</td>
</tr>
<tr>
<td>Approximately 73% of respondents to the online survey identified that cannabis is a main consumer substance of concern within the region.</td>
<td>Approximately 73% of respondents to the online survey identified that cannabis is a main consumer substance of concern within the region.</td>
</tr>
<tr>
<td>Qualitative insights from participants in a study on the unintended impacts of alcohol restrictions on AOD use in Indigenous communities in Queensland (10 LGAs in NQPHN) acknowledged that Cannabis is readily available in their communities. Many participants perceived that the restriction of alcohol consumption in some of the communities has resulted in an increase in gunja (cannabis) (Robertson, Fitts, &amp; Clough, 2017).</td>
<td>Qualitative insights from participants in a study on the unintended impacts of alcohol restrictions on AOD use in Indigenous communities in Queensland (10 LGAs in NQPHN) acknowledged that Cannabis is readily available in their communities. Many participants perceived that the restriction of alcohol consumption in some of the communities has resulted in an increase in gunja (cannabis) (Robertson, Fitts, &amp; Clough, 2017).</td>
</tr>
</tbody>
</table>

### Impacts of methamphetamine use

| The needs assessment identified that the use of methamphetamines (Ice) by people in the region is impacting on families, friends and the broader community. The lack of information and difficulty in accessing services and help was also a key concern identified. Within the state, access to culturally effective resources is difficult with most communities requesting local resources with localised content and contact information. Consultations with services pertaining to Ice and other drugs, and perceived community knowledge, has | During the stakeholder consultations across the region, the most commonly cited principal drug of concern is alcohol (65%) followed by cannabis (28%), and volatile solvents and amphetamines (2%). This is consistent with the cumulative data which shows alcohol as the most commonly cited principal drug of concern (42%), followed by amphetamines (24%) and cannabis (23%) (Queensland Network of Alcohol and Other Drug Agencies 2015). More than half the people entering treatment for their AOD use identified poly-drug use, with 63% of people who identified amphetamines as their primary |

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## Outcomes of the health needs analysis

<table>
<thead>
<tr>
<th>Strengthen capacity of primary health care sector</th>
<th>Community consultations across the AOD sector in NQPHN identified the need to strengthen the capacity of the primary health care sector to effectively manage a range of AOD issues. This was particularly highlighted in the Aboriginal community controlled health sector. Capacity development activities included screening, brief intervention, counselling and case coordination.</th>
</tr>
</thead>
</table>
| Community feedback identified the need for early support to families of people who have AOD issues to prevent breakdown of families and potentially child safety issues. 81% of respondents to the online survey identified that amphetamines/methamphetamines are a main substance of concern within the region. Methamphetamine Hospital admission in Queensland;  
- At the state level (Queensland) between 2009-10 and 2015-16, the annual rate of hospital admission related to methamphetamine increased from 3.9 to 79.0/100,000.  
- Patients 16 – 34 years aged group had the highest rate of hospital admission (7.6/100,000)  
- Aboriginal and Torres Strait Islander had more methamphetamine-related hospital admission rate compare to non-indigenous people (343.2/100,000 vs 70.6/100,000)  
(Queensland Government (Queensland Health), 2017) | Evidence suggest that AOD should be embedded across primary health care in line with a multidimensional concept of health that includes AOD and mental health, but which also encompasses domains of health and wellbeing such as connection to land or ‘country’, culture, spirituality, ancestry, family and community.  
Furthermore, the National Aboriginal and Torres Strait Islander Peoples’ Drug Strategy 2014 – 2019 identifies as its Priority One: ‘to build capacity and capability of the AOD service system, particularly Aboriginal and Torres Strait Islander controlled services and its workforce…’ |

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23 Queensland Network of Alcohol and Other Drug Agencies. NGO AOD Services – Northern Queensland  
25 National Aboriginal and Torres Strait Islander Peoples’ Drug Strategy 2014 - 2019
### Outcomes of the health needs analysis

<table>
<thead>
<tr>
<th>Co-occurrence of AOD use disorder with a mental health condition (dual diagnosis)</th>
<th>A mental illness concurrent with substance use tends to exacerbate both the mental illness and harmful substance use.</th>
<th>Community consultations in all areas within the region identified concerns about the lack of coordination and collaboration between AOD and mental health services and the difficulties experienced by individuals with comorbid conditions accessing coordinated care and support. Nationally, 35% of people (31% men and 44% women) who use drugs also have a co-occurring mental illness (Marel C et al., 2016). Although people with mental illness benefit from alcohol, tobacco and other drug treatment, they have poorer physical and mental health. Consultations within the region raised concerns that in some communities the mental health services do not always adequately assess substance use well, as alcohol and other drug services do not assess mental illness.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harmful use of alcohol and other drugs by young people</td>
<td>The needs assessment highlighted the concern across the NQPHN region around the harmful use of alcohol and other drugs by young people and the impact that this has on family and friends. Stakeholder feedback indicated that existing services were already at capacity to support young people. Young people within the NQPHN region face very complex social issues, some of which are particularly relevant to Aboriginal and Torres Strait Islander young people as well as the ongoing complexities caused by high youth unemployment rates and homelessness.</td>
<td>Evidence suggest that young people in the FNQ region are significantly disadvantaged in relation to their Queensland counterparts. In 2011, 36% of residents were in the most disadvantaged quintile, while in the discrete Aboriginal and Torres Strait Islander communities, 100% were in the most disadvantaged quintile. (ABS 2013). The 2014-15 National Health Survey data for Queensland indicated that young people aged 18-24 years consumed alcohol at high-risk levels (3.5%) compared to all older age groups in the past week (Source: AIHW data). 40.8% of young people aged 10-29 years reported alcohol as the principal drug of concern in 2015-16, (AIHW Data 2017).</td>
</tr>
</tbody>
</table>
# Outcomes of the health needs analysis

| Insufficient monitoring and evaluation systems and processes | At this stage there is insufficient systems and processes across the region to ensure that sufficient data is being collected and collated to measure impact of the service provision across the NQPHN footprint. Relationships, partnerships and collaborative arrangements are being | There is a need for the NQPHN to further develop links at both a state and local level to capture data and information to further understand the responsiveness, effectiveness and overall performance of the mental health service system within the region. |

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In July 2015 Cairns had the highest youth unemployment rate for QLD at 22.1%.  
Anecdotal and quantitative evidence from service providers within the region suggests that substance abuse and contact with the justice system have increased amongst Aboriginal and Torres Strait Islander young people over the past few years. This is believed to be symptomatic of broader social problems within the community. Government reports show that the region experiences high rates of youth suicide; completion rates for high school or further training are low; and the teenage birth rates are high. In addition, Cairns has the second highest rate of youth justice orders in the State; high levels of homelessness and high unemployment rates (Department of Communities, Social Planner 2010). Consultation feedback identified the concerns as:  
- serious issues in relation to poly drug use amongst groups of vulnerable young people in the region  
- significant issues with community safety and public amenity relating to young people and drinking alcohol and inhalant use  
- lack of programs for young people to reduce risks associated with drug and alcohol misuse  
- lack of treatment and rehabilitation services for youth and in particular services that meet the needs of Aboriginal and Torres Strait Islander youth from rural and remote locations.  

Escalation in methamphetamine use and dual diagnosis issues was reported across the region.  

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26 Cairns Alliance of Social Services: Position Paper 2016
<table>
<thead>
<tr>
<th>Outcomes of the health needs analysis</th>
</tr>
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<tbody>
<tr>
<td>established across the NQPHN region. As these further develop systems will improve.</td>
</tr>
</tbody>
</table>
### SECTION 3 – OUTCOMES OF THE SERVICE NEEDS ANALYSIS

This section summarises the findings of the AOD service needs analysis in the table below.

<table>
<thead>
<tr>
<th>Identified Need</th>
<th>Key Issue</th>
<th>Description of Evidence</th>
</tr>
</thead>
</table>
| The NQPHN AOD service needs assessment 2016-17 identified lack of systematic    | lack of systematic coordination between AOD primary health care services    | Feedback from stakeholder/community consultations and online survey identified:  
| coordination between AOD primary health care services and related services in   | and related services in the region. There are difficulties in accessing    | • increase service delivery planning and integration at a local level  
| the region. There are difficulties in accessing and lack of AOD services in the | and lack of AOD services in the rural and remote communities especially in  | • lack of cross-sector structures and support mechanisms – e.g. AOD treatment  
| rural and remote communities especially in the Aboriginal and Torres Strait    | the Aboriginal and Torres Strait Islander communities. There is a need to  | needs to link with employment support to jointly support transitions to  
| Islander communities. There is a need to enhance the capacity of AOD health   | enhance the capacity of AOD health workers in the region and additional    | employment  
| workers in the region and additional rehabilitation facilities across the       | rehabilitation facilities across the NQPHN. There are emerging AOD        | • recent consultations with Clinical Councils in the NQPHN identified similar  
| NQPHN. There are emerging AOD service needs for specific groups within the     | service needs for specific groups within the region, (Aboriginal and       | concerns as stakeholders in the region.  
| region, (Aboriginal and Torres Strait Islander, young people, homeless people, | Torres Strait Islander, young people, homeless people, LGBTI, 'Fly in     | Feedback from peak statewide agencies, local experts and NQPHN Clinical  
| LGBTI, ‘Fly in and Fly out' workers and transitional ex-inmates) and AOD        | and Fly out' workers and transitional ex-inmates) and AOD after hours    | Councils identified:  
| after hours services.                                                          | services.                                                                 | • identify and promote referral pathways that enhance access to wrap-around  
|                                                                                |                                                                          | services that support individuals, families and communities; engage in local  
|                                                                                |                                                                          | level AOD/ice planning  
|                                                                                |                                                                          | • improve coordination of AOD and related services between sectors  
| Better integration and coordination between sectors and services               | Lack of coordination and communication between services and sectors that   | • coordinate with existing services to avoid overlap and expand capacity to  
|                                                                                | is impacting on continuity of care.                                       | accommodate all individuals in need of treatment  
|                                                                                |                                                                          | • co-locate mental health and AOD services as a strategy to improve  
|                                                                                |                                                                          | coordination  

The current AOD service needs outcome indicated that it aligns well with the National and NQPHN Alcohol and Other Drugs strategic framework. The update in this section is very limited as the qualitative data presented remain valid and where applicable quantitative data are incorporated.
## Outcomes of the service needs analysis

<table>
<thead>
<tr>
<th>Support and expand appropriate services for Aboriginal and Torres Strait Islander people</th>
<th>There is a need to improve access for Aboriginal and Torres Strait Islander people experiencing AOD harm by supporting, enhancing and expanding service options for Aboriginal and Torres Strait Islander people. There is a need to build capacity and capability of the AOD service system, particularly Aboriginal and Torres Strait Islander community-controlled services and its workforce to manage individuals and families with AOD issues. Integral to building the supply of an Aboriginal and Torres Strait Islander AOD workforce is the need to ensure staff are suitably trained and supported.</th>
</tr>
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<tr>
<td></td>
<td>• need for a central organisation to co-ordinate regular communication between all AOD services. Currently state-based organisations do not necessarily communicate to all stakeholders e.g. government and NGOs • improve integration and collaboration between health services and other services e.g. housing, health, employment, education • adequate funding and resources required to provide evidence-based, sufficient and timely initiatives with a focus on the provision of resources to the AOD treatment sector. Analysis of local service planning reports and initial service mapping activities: • need for increased opportunities for Aboriginal and Torres Strait Islander communities to develop their own AOD local area plans and strategies • service mapping did not include details regarding existing coordination and collaborative mechanisms • Consumers finding it difficult to navigate between different service providers</td>
</tr>
<tr>
<td>Feedback from stakeholder and community consultations identified:</td>
<td>• the need for more Aboriginal and Torres Strait Islander staff with AOD skills to improve access for Aboriginal and Torres Strait Islander people • very limited specified positions for Aboriginal and Torres Strait Islander people locally particularly in general practice • Aboriginal and Torres Strait Islander staff employed can feel isolated and experience burn out due to high workloads. It was suggested that more Aboriginal and Torres Strait Islander staff would support more culturally appropriate responses and approaches to AOD treatment and harm minimisation. A recent draft report on service gaps in the Cape York region has identified AOD as one of the top 10 service needs in the Aboriginal communities (Regional Health Partners, 2017). Feedback from peak statewide agencies, local experts and NQPHN Clinical Councils identified: • lack of dedicated AOD positions within the Aboriginal community controlled health sector</td>
</tr>
</tbody>
</table>
**Outcomes of the service needs analysis**

<table>
<thead>
<tr>
<th>Need for additional treatment capacity and equitable distribution within the specialist AOD sector across the region, in particular rural and remote areas.</th>
<th>Demand for AOD services exceeds supply throughout the region. There are only a few non-government organisations currently operating services within the region in addition to the region specific services provided by the HHSs. In some rural and remote sites there are isolated workers with minimal support structures.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feedback from stakeholder/community consultations and online survey identified:</td>
<td>increase the range and accessibility of AOD treatment services across all areas within the region. Universally cited issue across all HHS regions</td>
</tr>
<tr>
<td>• there is need for strategies that grow an Aboriginal and Torres Strait Islander AOD workforce (QAIHC) as currently there is a labour skills shortage</td>
<td>ICE is an emerging issue – it is accessible and cheap; alcohol, marijuana, tobacco are other problem drugs. Areas within Mackay and Townsville regions in particular identified a rise in ICE related issues</td>
</tr>
<tr>
<td>• the National Aboriginal and Torres Strait Islander Peoples’ Drug Strategy 2014-2019 identified the need to ‘build capacity and capability of the AOD service system, particularly Aboriginal and Torres Strait Islander community-controlled services and its workforce services’ as a key priority area</td>
<td>• FASD is still a big issue and not being addressed across the region</td>
</tr>
<tr>
<td>• need for a clear career pathway for Aboriginal and Torres Strait Islander AOD workers</td>
<td>• in general across the NQPHN region, it was identified a need for: increased capacity in residential rehabilitation services; increased availability of diversionary, case management and assertive outreach programs – particularly for young people and people from Aboriginal and Torres Strait Islander backgrounds; increased availability of residential detox facilities; AOD health promotion; AOD services in rural areas</td>
</tr>
<tr>
<td>• need for skilled Aboriginal and Torres Strait Islander primary health care workforce with confidence to deliver AOD support.</td>
<td>• need for services targeting women including maternal and child health services. This was particularly noted as a need for Aboriginal and Torres Strait Islander women within the Cairns, Cape York and Torres Strait regions</td>
</tr>
<tr>
<td>• High turnover of professional staff</td>
<td>• recent consultations with Clinical Councils in the NQPHN identified similar concerns as stakeholders in the region</td>
</tr>
</tbody>
</table>
| • 28% of respondents to the online survey identified that drug and alcohol treatment needs in their region are being met ‘not at all’. 53% of respondents
| Outcomes of the service needs analysis | identified that these treatment needs are being met ‘somewhat’. Respondents identified youth, Aboriginal and Torres Strait Islander people, and people in rural and remote areas as those most in need of AOD services. Feedback from peak statewide agencies, local experts and NQPHN Clinical Councils identified:  
• an increase in demand of clients with more complex issues including co-morbidities (mental health and chronic disease) and poly drug addiction  
• a lack of residential rehabilitation services across Queensland and lack of dedicated AOD positions within the Aboriginal community controlled health sector (specifically for ice)  
• demand for residential detox facilities to ensure a transition pathway to rehab facilities  
• enhance health professionals’ skills to deliver AOD intervention – in both the primary health care and emergency settings  
• increase workforce development for the AOD sector and create a sustainable AOD workforce that is capable of meeting future challenges. Analysis of local service planning reports and initial service mapping activities:  
• an underinvestment in the specialist AOD treatment sector across the NQPHN region with a particular need for additional services in the rural areas.  
• as identified by QNADA, there are a few non-government organisations currently operating services within the region in addition to the region specific services provided by the HHSs.  
The service mapping indicates limited specialist AOD services within the region, especially outside of the major regional centres. The regularity of QH AOD services to rural, remote and remote Aboriginal and Torres Strait Islander communities in unknown, as is the extent to which they provide support to youth. The service mapping indicates that there are only a handful of community-based AOD counselling and support services across the NQ region, and none in the rural towns and remote and remote Aboriginal and Torres Strait Islander communities. The rate of overnight hospitalization for AOD misuse in the rural and remote at SA3 level is higher the outer regional centers within NQPHN (180/100,000): |

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Department of Health PRIMARY HEALTH NETWORKS Needs Assessment reporting template

Page 26
### Outcomes of the service needs analysis

<table>
<thead>
<tr>
<th>Additional capacity within rehab facilities – including additional capacity to support the particular needs of individuals and families</th>
<th>Limited available rehab facilities with the region and the existing facilities do not have capacity to cater to the particular needs of individuals and families needing treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feedback from stakeholder and community consultations identified:</td>
<td></td>
</tr>
<tr>
<td>• a need to increase the access and availability of rehab facilities. These issues were of concern across the whole NQPHN footprint. There are often waiting lists, so critical opportunities for engagement are missed</td>
<td></td>
</tr>
<tr>
<td>• concerns were expressed about the cultural competency of some services – with low Aboriginal and Torres Strait Islander client numbers at some facilities</td>
<td></td>
</tr>
<tr>
<td>• feedback and discussion around the existing facilities identified that some of the existing facilities may not be utilised in a way that currently meet the needs of the communities</td>
<td></td>
</tr>
<tr>
<td>• a need to increase access to primary health on-site for residential rehabilitation services; address physical health, child and maternal health, and SEWB in addition to substance use.</td>
<td></td>
</tr>
<tr>
<td>• a need for residential rehab facilities to support specific groups (e.g. youth, women, families, Aboriginal and Torres Strait Islander people)</td>
<td></td>
</tr>
<tr>
<td>• a need to work with families to support people through the rehab journey – all programs need to be holistic</td>
<td></td>
</tr>
<tr>
<td>• 75% of respondents to the online survey identified rehab services as being required locally to address the needs of those who are missing out on services.</td>
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</tr>
<tr>
<td>Feedback from peak statewide agencies, local experts and NQPHN Clinical Councils identified:</td>
<td></td>
</tr>
<tr>
<td>• lack of residential rehabilitation services across Queensland</td>
<td></td>
</tr>
<tr>
<td>• demand for residential detox facilities – too problematic with day detox process</td>
<td></td>
</tr>
<tr>
<td>• facilities where there are large numbers of Aboriginal and Torres Strait Islander clients that are not accessing service – funding bodies support culturally effective inclusive strategies</td>
<td></td>
</tr>
<tr>
<td>• current family-centred facility requires Indigenous governance to ensure culturally safe and effective strategies are implemented.</td>
<td></td>
</tr>
</tbody>
</table>

Analysis of local service planning reports and initial service mapping activities:
<p>| Outcomes of the service needs analysis | | |
|---------------------------------------|---------------------------------------------|
| <strong>Needs Assessment reporting template</strong> | <strong>Primary Health Networks</strong> | <strong>Page 28</strong> |
| <strong>Need for additional detox facilities in the region that provide services for specific population groups such as youth and women</strong> | <strong>Very limited in-patient detox facilities in the region</strong> | <strong>Feedback from stakeholder/community consultations and online survey identified:</strong> |
| | | <strong>- across the region the need for additional detox facilities was identified. Whilst some feedback from individuals was around the suitability of day detox, others identified that the need was in relation to residential detox facilities as it was hard to do day detox then go home to same situation at night</strong> |
| | | <strong>- the Torres Strait identified a need to have local access to detox and well as rehab facilities</strong> |
| | | <strong>- respondents to the online survey identified that withdrawal management services are the principally needed services to address the needs of people who are missing out on services in the region – closely followed by rehab services and counselling.</strong> |
| | | <strong>Feedback from peak statewide agencies, local experts and NQPHN Clinical Councils identified:</strong> |
| | | <strong>- funding to support detox beds are made available for specific facilities to trial with a long term focus on further investment</strong> |
| | | <strong>- increase access to AOD treatment and support services for young people</strong> |
| | | <strong>- funding to support integrated service provision to vulnerable young people.</strong> |
| | | <strong>Analysis of local service planning reports and initial service mapping activities:</strong> |
| | | <strong>- need increased availability of residential detox facilities.</strong> |
| | | <strong>- culturally appropriate detoxification services to effectively meet the needs of young people from rural and remote locations.</strong> |
| <strong>Need for AOD services for young people</strong> | <strong>Not enough AOD services and workers to support young people - especially in rural and remote communities.</strong> | <strong>Feedback from stakeholder/community consultations and online survey identified:</strong> |
| | | <strong>- across the whole region the need for additional services and service capacity was identified</strong> |
| | | <strong>- there are no rehab services for young people within the region.</strong> |</p>
<table>
<thead>
<tr>
<th>Outcomes of the service needs analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>- serious issues in relation to poly drug use amongst groups of vulnerable young people in the region; significant issues with community safety and public amenity relating to young people and drinking alcohol and inhalant use; escalation in methamphetamine use and dual diagnosis issues in Cairns, Townsville and Mackay</td>
</tr>
<tr>
<td>- long waiting lists exist for QH youth AODs</td>
</tr>
<tr>
<td>- no specialised AOD services in Cape York for young people</td>
</tr>
<tr>
<td>- difficult to access AOD counselling in rural areas</td>
</tr>
<tr>
<td>- need increased access to AOD services for young people; more education in schools; youth groups; prevention and early intervention; culturally appropriate ways to connect with Aboriginal and Torres Strait Islander young people; in conjunction with AOD treatment, young people often also require support with rebuilding their relationships with family and community</td>
</tr>
<tr>
<td>- respondents to the online survey identified youth as the group most in need of AOD services.</td>
</tr>
</tbody>
</table>

Feedback from peak statewide agencies, local experts and NQPHN Clinical Councils identified:
- a clear need to increase youth related AOD services within the NQPHN with a focus on afterhours care/programs.
- research into a successful model for outstation/homeland programs for at risk young people.
- support AOD youth focused workforce to deliver family responsive information/resources.

Analysis of local service planning reports and initial service mapping activities:
- need for diversionary programs for young people aimed at supporting young people to reduce risks associated with drug and alcohol misuse; treatment and rehabilitation - including culturally appropriate detoxification and residential rehabilitation services to effectively meet the needs of Aboriginal and Torres Strait Islander youth from rural and remote locations; case management and assertive outreach programs.
### Outcomes of the service needs analysis

| Establishment of services and stronger support mechanisms for individuals transitioning from prison to rehab/community (both adult and youth) | There are no systematic linkages to primary care or other services for individuals transitioning from prison to rehab or back to community | Feedback from stakeholder/community consultations and online survey identified:  
- this key service need was identified across the region. This included the need for post release programs (from rehab and prison) – including care-coordination and a step out'/community reintegration facilities for individuals on release from prison  
- support for prisoners needs to include provision of AOD treatment within the prison setting as also identified.  
Feedback from peak statewide agencies, local experts and NQPHN Clinical Councils identified:  
- a coordinated approach between QCS, rehab facilities and other government and NGOs to transition across AOD services  
- provide greater support to clients transitioning from prison, including provision of AOD treatment within the prison setting e.g. step in – step out facilities and programs.  
Analysis of local service planning reports and initial service mapping activities:  
- build and strengthen partnerships with key agencies to advise and provide support to address AOD harm among offenders.  
The service mapping indicates that there are no specific services targeting this issue. However, more detailed and localised service mapping is required to better understand the localised service systems. |
<table>
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<tbody>
<tr>
<td>Additional service capacity required within the region to respond to ice</td>
<td>Many services within the region feel unequipped to effectively support people using</td>
<td>Feedback from stakeholder/community consultations and online survey identified:</td>
</tr>
</tbody>
</table>
### Outcomes of the service needs analysis

| Additional services and support for families and carers of AOD users – particularly ice | The need for increased services and support for families/carers for ice users was identified as a key area of service need. Consultations identified that approaches that would meet the needs included support groups, counselling and also peer support. | Feedback from stakeholder/community consultations and online survey identified:  
- families identified that they were struggling with what to do and how best to support their loved ones. This was particularly highlighted in the Townsville and Mackay region. They identified the need for the establishment of family support groups in major northern centres as well as services to the families of people who have AOD issues - to avoid the breakdown of families and/or intervention by Child Safety.  
Analysis of local service planning reports and initial service mapping activities:  
- the initial service mapping identified that most NGOs provide what they can as part of their service, however there are no organisations specifically funded to provide this. |
<table>
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<tbody>
<tr>
<td>Additional services and increased service capacity in relation to health</td>
<td>A need to increase the availability and services around alcohol and other drugs</td>
<td>Feedback from stakeholder/community consultations and online survey identified:</td>
</tr>
</tbody>
</table>
### Outcomes of the service needs analysis

| Promotion, early intervention and prevention | Information and educational sessions was identified across the region. This was highlighted as a need to increase services and groups for men across Cape York and the Torres Strait. | • ICE education and training is required around re-emerging drug issues – community members wanting to form AOD groups to learn more  
• need for localised resources to provide health education about AOD issues  
• need for health promotion/early intervention services, including educational programs (e.g. men’s groups).  
• AOD health promotion programs in Schools (especially in rural and remote communities).  
Feedback from peak statewide agencies, local experts and NQPHN Clinical Councils identified:  
• funding opportunities for health promotion and health education programs with localised content needed  
• frontline workers require regular upskilling in areas of emerging AOD issues.  
Analysis of local service planning reports and initial service mapping activities:  
• need for additional AOD health promotion across the region but in particular rural and remote areas.  
The service mapping indicates that there are very few AOD services providing AOD health promotion and early intervention and prevention. However more detailed and localised service mapping is required to better understand the localised service systems, as this may be part of the general primary health care health education program. |
| Increase the supply of AOD workers | The needs assessment identified a lack of specific alcohol and other drug workers across the region particularly in rural and remote areas and the Torres Strait. | Feedback from stakeholder/community consultations and online survey identified:  
• consistent message from consultations and online survey was the lack of specific AOD workers in many areas within regions. This was particularly noted as a priority for rural/remote communities and the Torres Strait.  
• QH AOD teams in some HHS regions had reduced capacity over recent years (e.g. Mackay, Cape/Torres, Townsville).  
• survey results indicated that 50% of providers specifically identified the need for psychology services and 50% for Aboriginal and Torres Strait Islander mental health workers to address workforce gaps in AOD  
• 72% of respondents to the online survey identified AOD counselling as being required locally to address the needs of those who are missing out on services. |
### Outcomes of the service needs analysis

| Increase the capacity of the existing AOD workforce to better support people experiencing AOD issues | Feedback from peak statewide agencies, local experts and NQPHN Clinical Councils identified:  
- Queensland Aboriginal and Islander Health Council and the Queensland Indigenous Substance Misuse Council as the respective peaks for Aboriginal and Torres Strait Islander community controlled health and AOD services identified the need to ‘lobby for resources to meet current and emerging service demand’ as a key sector priority  
- local experts including QAIHC supported the need to grow a local workforce, in particular Aboriginal and Torres Strait Islander AOD workers  
- experts locally and from peak bodies believe that this unmet need is accurate for the NQPHN region.  
- the need to build the capacity of Aboriginal and Torres Strait Islander mental health workers and further develop more effective models to meet the needs of the community is required.  
Analysis of local service planning reports and initial service mapping activities:  
- the New Horizons Report, a national review of alcohol and other drug treatment services in Australia identified a ‘substantial unmet demand’ (p. 183). The research estimated that approximately 200,000 people receive AOD treatment in any one year in Australia. At the same time, modelled projections of the unmet demand for AOD treatment (that is the number of people in any one year who need and would seek treatment) are conservatively estimated to be between 200,000 and 500,000 people over and above those in treatment in any one year.

| NGO AOD workers across the region identified the need to increase their skills and capacity to effectively treat and support people experiencing AOD issues. On-site training for residential rehab facilities should be considered as staff often have difficulty in being released to attend training due to backfilling. | Feedback from stakeholder/community consultations and online survey identified the following key training priorities:  
- working with complex trauma  
- cultural competence - culturally appropriate responses and approaches to AOD treatment and harm minimisation as traditional approaches are not always very useful  
- ensuring all staff have formal qualifications – several organisations would like to support all staff to complete Cert IV or higher in AOD qualifications |
### Outcomes of the service needs analysis

| Increase the capacity of GPs and other primary care and community sector workers to better support people experiencing AOD issues | GPs and other primary care and community sector workers lack capacity to effectively support those with AOD issues. Currently there are no primary healthcare guidelines for working with Aboriginal and Torres Strait Islander communities around drug and alcohol issues that are followed across the region. The AOD workforce comes from a wide variety of backgrounds and the health care services

- ICE and other emerging drug issues
- withdrawal support
- training for pharmacists (e.g. mental health first aid) and identification of at-risk patients to refer to AODs
- dual diagnosis.

Feedback from peak statewide agencies, local experts and NQPHN Clinical Councils identified:
- need for a coordinated approach to AOD workforce support and development
- training and professional development for front line staff is critical
- there is a range of training being delivered by key agencies including INSIGHT Training and Education Unit, Queensland State Government and Dovetail, however, one of the challenges lies with staff shortages not enabling staff to be released for training; or high staff turnover resulting in a constant need for upskilling
- on-site training/upskilling for AOD workforce e.g. digital/RTO on-site – addresses issues of staff attendance
- front line staff require information/skilling/debrief/supervision/mentoring about emerging AOD issues on a regular basis.

Analysis of local service planning reports and initial service mapping activities:
- workforce mapping indicated that there is a need for improved training pathways including developing strategies and pathways into the VET and university sector.

Feedback from stakeholder/community consultations and online survey identified:
- widely noted issue across the region. GPs, psychologists usually have limited training in AOD
- feedback from service providers in the primary healthcare sector indicated staff felt they had a lack of skills and confidence in addressing drug and alcohol issues with individuals and families
- training priorities included: use of screening and assessment tools; brief interventions; motivational interviewing; stages of change model; and understanding referral options

- Increase the capacity of GPs and other primary care and community sector workers to better support people experiencing AOD issues

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## Outcomes of the service needs analysis

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Other Service Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>require support around service delivery and service delivery models to embed drug and alcohol services within their primary healthcare services.</td>
<td>other service needs included ensuring more GPs and pharmacists are qualified to run opioid programs need to embed AOD workers in GP practices and the need to upskill workers in new/emerging drugs (ice).</td>
</tr>
</tbody>
</table>

Feedback from peak statewide agencies, local experts and NQPHN Clinical Councils identified:
- AOD intervention training for all frontline staff including administration, primary health care, general practice and allied health staff
- increase AOD workforce in primary health care and general practice facilities.

Analysis of local service planning reports and initial workforce mapping activities:
- the need to increase opportunities for student placements in AOD settings during vocational, undergraduate and post graduate education by supporting local universities to establish AOD student placement options.

### Sustainable AOD workforce

<table>
<thead>
<tr>
<th>Difficulty</th>
<th>Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulties with retention of staff – which impacts on continuity of care and provision of services, was identified as a key service issue. There is a need for strategies to retain workers in AOD workforce including ensuring support for debriefing ensuring wellbeing and ensuring staff have access to professional development, supervision and mentoring. There is a need to support:</td>
<td>Feedback from stakeholder/community consultations and online survey identified:</td>
</tr>
</tbody>
</table>
| • systems to provide adequate supervision and support; including policy and procedure for staff to access debriefing, counselling and employee assistance programs.  
• systems to ensure adequate continuing professional development. | • issues with retention of staff were identified across the whole region. These included high workload, lots of staff burn out, limited access to debriefing, counselling, lack of clear training pathways and career pathways as well limited structured continuing professional development
• another issue identified as contributing to staff turnover for Aboriginal and Torres Strait Islander staff was a lack of cultural safety within the organisations they were employed. |

Feedback from peak statewide agencies, local experts and NQPHN Clinical Councils identified:
- QAIHC identified high burn out rates as a key issue and suggested wage parity based on qualification and skill levels was required; along with more opportunities to access VET training (Diploma Level Qualifications) to meet the complex needs of presenting clientele
- need for a clear career pathway for AOD workers.

Analysis of local service planning reports and initial service mapping activities:
- need a sustainable AOD workforce in the NQPHN region that is capable of meeting future challenges, innovation and reform.

Organisations have structures, policies, and programs that move the workforce along the continuum from Aboriginal and Torres Strait
### Outcomes of the service needs analysis

| Islander cultural awareness, to cultural sensitivity, ultimately to cultural safety. A percentage of PHN funds would be allocated to enable this to occur | • a key service need identified locally was the need to ensure all organisations had structured continuing professional development systems in place for their staff.  
• Improving quality of employment for rural and remote workers |
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Insufficient monitoring and evaluation systems and processes</strong></td>
<td>At this stage there are insufficient systems and processes across the region to ensure that sufficient data is being collected and collated to measure impact of the service provision across the NQPHN footprint. Relationships, partnerships and collaborative arrangements are being established across the NQPHN region. As these further develop, systems will improve.</td>
</tr>
</tbody>
</table>
## SECTION 4 – OPPORTUNITIES, PRIORITIES AND OPTIONS

This section summarises the priorities arising from the Needs Assessment and options for how they will be addressed.

<table>
<thead>
<tr>
<th>Priority Issue</th>
<th>Actions</th>
<th>Who (lead)</th>
<th>Expected outcome (performance indicator)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cairns</strong></td>
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</tbody>
</table>
| Coordination between sectors to address dual diagnosis issues including hospitals, NGO’s and GP’s. | • Need inclusive models/no wrong doors  
• PHN could act as facilitator to improve coordination of services  
• Use QAIHC model of care – looks at whole person (physical, mental, housing, legal etc.).  
• Workforce - need to ensure all staff have skills/whole team approach | • Consumer voices/lived experience/groups/the individual.  
The sector, which includes:  
• Health services, GP’s  
• NGO’s  
• AOD Peak  
• Police (legal responsibility to enforce the law). | • Improved service coordination between providers |
| Support and expand appropriate services for Aboriginal and Torres Strait Islander people | • Training - upskilling capacity  
• Develop Aboriginal and Torres Strait Islander workforce.  
**Build strengths**  
• Community Controlled Rehabs  
• Health Centres  
• NGO’s  
• Sporting Clubs  
• Men’s Groups/Women’s Groups  
• Youth Groups. | • NGO’s  
• Community Controlled services  
• Parole  
• CREST  
• Prisons. | • Decrease in re-offending  
• Increase in wellbeing. |
| Additional capacity within residential rehab facilities – including additional capacity to support specific population groups such as youth, women and families. | • Better assessment – holistic/including ABI/FASD  
• Detox in rehab  
• Targeted young person’s rehab (locally)  
• Very quick turnover/referrals | • Residential rehabs.  
• Community controlled services  
• QNADA  
• QISMA  
• NGO’s  
• AMS. | • Increased number of beds  
• Easier referral pathways  
• Improved Recovery  
• Improved Co-ordinated services. |
<table>
<thead>
<tr>
<th>Impact of alcohol and other drugs on infants and children (FASD)</th>
<th>Increased support with young women and men</th>
<th>Youth services</th>
<th>Enhanced Diagnostic recognition</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Increased PUP programs – pregnancy programs</td>
<td>Health Centres</td>
<td>Increased education and understanding of FASD</td>
</tr>
<tr>
<td></td>
<td>Increased ante natal service – skilled nurses</td>
<td>GP’s</td>
<td>Decrease of AOD use in pregnancy.</td>
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<tr>
<td></td>
<td></td>
<td>HHS</td>
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<td></td>
<td></td>
<td>Ante Natal services</td>
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<td></td>
<td></td>
<td>AMS</td>
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<td></td>
<td></td>
<td>Schools</td>
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<table>
<thead>
<tr>
<th>Increased access to AOD services for young people</th>
<th>Increased treatment positions</th>
<th>Youth services</th>
<th>Improved early intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prevention and intervention (young mums, women)</td>
<td>Schools</td>
<td>Increased Social and Emotional Wellbeing in young people.</td>
</tr>
<tr>
<td></td>
<td>Better holistic assessment/ diagnostic</td>
<td>AMS</td>
<td>Decreased AOD use</td>
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<tr>
<td></td>
<td>Coordinated services</td>
<td>Youth Justice and Community Services</td>
<td>Better assessment: diagnostic.</td>
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<tr>
<td></td>
<td>Support families</td>
<td>Communities</td>
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<td></td>
<td>Inreach that is client centred/client needs focus.</td>
<td>Dovetail</td>
<td></td>
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<tr>
<td></td>
<td>AOD rest and recovery.</td>
<td>Family Nurse (FNP)</td>
<td></td>
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<tr>
<td><strong>Build strengths</strong></td>
<td></td>
<td>QPS/QAS</td>
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<tr>
<td></td>
<td>Existing Programs</td>
<td>Emergency Department.</td>
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<td>CCYP</td>
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<td></td>
<td>Existing networks</td>
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<td></td>
<td>Sporting/community clubs.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Build strengths</th>
<th>Co-ordinated post supports and programs</th>
<th>Flexible model- culturally appropriate.</th>
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</thead>
<tbody>
<tr>
<td>Residential rehabs.</td>
<td></td>
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<tr>
<td>Community controlled services</td>
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<td></td>
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<tr>
<td>QNADA</td>
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<tr>
<td>QISMA</td>
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<td>NGO’s</td>
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<td>AMS</td>
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</tbody>
</table>

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Page 38
- Better assessment and training to identify FASD
- Better supports
- Better resources applicable to FASD e.g. care plan and interventions.

**Build strengths**
- Increased research into contemporary models of care
- Youth services
- Health Centres
- GP’s
- HHS
- Ante Natal services
- AMS
- Schools
- Sexual Health Services.

---

**Townsville**

Additional capacity within residential rehab facilities – specific populations

**Sub populations:**
- Women – safe places, family support, living, community support
- Ethnic and ATSI- culturally appropriate and competent (i.e. religious considerations), peer support
- Youth – 24/7 access, no referral system, no red tape, walk in
- Disabled, Rural and Remote, High performers/Miner FIFO/High income, Aged.

- Home detox
- Co-morbidities
- Models of service delivery/practice
- Not one size fits all – flexible (weekends, after hours)
- Strengthen capacity/capability of sub populations – GPs/Communities (i.e. MH First Aid and AOD First Aid training) to develop baseline skills
- Seamless pathways of care
- Multidisciplinary Allied health programs

**Resources:**
- All facilities provided rehab services
- Developed new models of service delivery
- Less emergency department admissions
- Less crime related to AOD
- Less re-admission
- Stable housing/general hygiene/employment/training – functioning
- Goal establishment and attainments – similar model to NDIS
- Decrease in relapse rate
- Increased attendance at check-ups – 13 and 26 weeks.
| Dual diagnosis - MH/AOD Integrated Services Models, Certificate IV Dual Diagnosis to build workforce professional capacity/skills in both areas. | • Training – at all/different levels for stepped care  
• Medical intervention for detox (acute)  
• Withdrawal support services – self-detox, community, online, home visits, phone, skype/blue jeans  
• Central case management – central resource, technology, lag measures. | • AOD providers  
• PHC Teams  
• GP's and associated staff  
• QH  
• Community organisations  
• Carer support – Narcotics anonymous  
• Schools  
• Seniors/carers  
• A&TSI  
• Service providers  
• Council,  
• QPS | • Developed carer support intervention  
• Increased level of community awareness- surveys, workshops and participation/ownership of addressing the issues.  
• Reduced number of people accessing services.  
• Evidence of individual and family goals met.  
• Decreased level of crime related to AOD (court orders, drug related offences – QPS stats, magistrate, courts).  
• Decrease level of admissions to residential rehabilitation centres and Emergency department.  
• Increased number of people participating in home-based activities/programs (detox early intervention).  
• Improved quality of health promotion and education: Families and individuals know where/how |
<table>
<thead>
<tr>
<th>Increase AOD afterhours services:</th>
<th>Improve Service Delivery:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current afterhours: Acute facilities (ED, QPS, DABIT), GPs, Emergency Responses.</td>
<td>Liaise with above organisations to understand service needs/gaps.</td>
</tr>
<tr>
<td></td>
<td>What should an afterhours service look like/address? Tiered/stepped care/needs.</td>
</tr>
<tr>
<td></td>
<td>Remote: upskilling workforce (education/training), virtual support, workforce retention.</td>
</tr>
<tr>
<td></td>
<td>Improved service coordination especially with community support (i.e. AA).</td>
</tr>
<tr>
<td></td>
<td>Townsville: opportunity to expand on existing services (ATODS), upskilling first responders, detox rehab.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Support/Expand AOD services for Indigenous Populations:</th>
<th>Culturally appropriate men/women/family</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mandated partnerships with existing service providers (i.e. regular stakeholder meetings).</td>
</tr>
<tr>
<td></td>
<td>Increased support and awareness for GPs around AOD</td>
</tr>
<tr>
<td></td>
<td>Building capacity of NGOs and Indigenous workers in mainstream positions</td>
</tr>
<tr>
<td></td>
<td>Cultural auditing and accountability</td>
</tr>
<tr>
<td></td>
<td>What works? Listen to community</td>
</tr>
</tbody>
</table>

|                                                          | Increased number of AOD afterhours services |
|                                                          | Improved quality of AOD afterhours services |
|                                                          | Improve quality of employment for AOD workers |

|                                                          | Increase AOD services for Aboriginal and Torres Strait Islander population |
|                                                          | Develop culturally appropriate AOD services for ATSI |
|                                                          | Establish contacts and awareness for GPs and AOD services with ATSI |
|                                                          | Improve employment quality for ATSI workers |

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Page 41
| Increase capacity of primary health care and other sectors re: drug and alcohol issues | **What:**  
- More Community outreach services and coordinating care with GPs.  
- Increase University involvement in evaluation and co-design.  
- Improve information sharing between agencies.  
- Greater consumer involvement in service design.  
**How:**  
- Recognising dual diagnosis (education).  
- Relapse prevention.  
- Workforce development and supervision (cross sector – youth, clinicians).  
- Early understanding of trauma. |
| --- | --- |
|  | **Consumers**  
- Family members. |
|  | **Increased awareness of relapse preventions**  
- Shared service documentation with Consumers  
- Improved understanding by consumers. |

**Mackay**

| Coordination between sectors to address dual diagnosis issues | **What:**  
- Address people who present to ED AOD specific work in ED – work with all parts of hospital health system. Police setting up a taskforce  
- Need community based AOD Rehabilitation Facilities that have 24 hour service  
- Need embedding of AOD workforce in the Primary Healthcare Sector and in E.D.’s  
- Development of Diversion strategy is also need perhaps using the Townsville model |
| --- | --- |
|  | **AOD providers**  
- NQPHN  
- HHS |
|  | **Established contacts with local services**  
- Create and maintain linkages between stakeholders |

| Dual Diagnosis (Whole of group response because of limited time available) | **What:**  
- Need community based AOD Rehabilitation Facilities that have 24 hour service  
- Need embedding of AOD workforce in the Primary Healthcare Sector and in E.D.’s  
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| --- | --- |
|  | **AOD providers**  
- NQPHN  
- HHS |
|  | **Develop a proposal for community base AOD 24 hour rehabilitation facilities**  
- Increased capacity of AOD workforce in primary health sector and emergency departments  
- Established diversion strategy |
<table>
<thead>
<tr>
<th>Torres and Cape</th>
<th>Actions</th>
<th>Who (lead)</th>
<th>Expected outcome (performance indicator)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need for additional treatment capacity and equitable distribution within the specialist AOD sector across the region, in particular rural and remote areas</td>
<td>Local community based withdrawal support and rehabilitation services including access to specialist input. The Torres Straits in particular need alcohol and drug (AOD) counselling with separate services for men and women ideally.</td>
<td>ACCHO’s</td>
<td>Increased access to residential rehabilitation services including support for people when they return home</td>
</tr>
<tr>
<td></td>
<td>Equitable access to culturally appropriate services for A&amp;TSI young people in the region</td>
<td>Existing NGO/ACCHOs that have the capacity</td>
<td>Implemented culturally appropriate withdrawal and rehabilitation services to meet the needs of young people</td>
</tr>
<tr>
<td>Additional services and increased service capacity in relation to health promotion, early intervention and prevention</td>
<td>Explore culturally appropriate models for AOD health promotion in the remote and rural areas</td>
<td>NGO/ACCHOs</td>
<td>Increased capacity of A&amp;TSI primary healthcare workforce and local community service providers to work with AOD issues.</td>
</tr>
</tbody>
</table>
|                | • Funding for additional A&TSI AOD workers  
• Support initiative that enhance access to VET and higher education AOD programs for A&TSI                                                                                                     | VET/TAFE/Universities | Increased number of A&TSI graduates trained in AOD and MH  
Increase opportunities and capacity for A&TSI communities to develop their own AOD local area plans and strategies. |
SECTION 5 - REFERENCES


Queensland Network of Alcohol and Other Drug Agencies LTD. (2016). *NGO AOD Services-Northern Queensland*. Retrieved from Brisbane:

